HEALTH SERVICES AND DEVELOPMENT AGENCY
DECEMBER 13, 2017
APPLICATION SUMMARY

NAME OF PROJECT:	Chattanooga-Hamilton County Hospital Authority d/b/a Erlanger Sequatchie Valley Regional Hospital-Satellite Emergency Department
PROJECT NUMBER:	CN1709-028
ADDRESS:	553 US Highway 127 Bypass Pikeville (Bledsoe County), TN 37367
LEGAL OWNER:	Chattanooga-Hamilton County Hospital Authority dba Erlanger Health System 975 East 3rd Street Chattanooga, TN 37403
OPERATING ENTITY:	N/A
CONTACT PERSON:	Joseph Winick (423) 778-8088
DATE FILED:	September 11, 2017
PROJECT COST:	$4,388,484.00
FINANCING:	Tax Exempt Bonds
PURPOSE FOR FILING:	Establishment of a satellite emergency facility with 7 treatment rooms

DESCRIPTION:

Chattanooga-Hamilton County Hospital Authority d/b/a Erlanger Sequatchie Valley Regional Hospital seeks approval for the establishment of a satellite emergency department (ED) containing 7 treatment rooms in an 8,100 square foot building to be constructed on a 4 acre site located at 533 US Highway 127 Bypass, Pikeville (Bledsoe County) TN.

A companion application, Erlanger Sequatchie Valley Regional Hospital, CN1709-027, will also be heard at the December 13, 2017 Agency meeting for the relocation and replacement of Erlanger Bledsoe Hospital (25 bed critical access hospital) with a new 61,500 SF facility that will be located at 17399 Rankin Avenue Dunlap, TN in adjoining Sequatchie County. The applicant will also seek approval for the establishment of a 3.0 Tesla magnetic resonance imaging (MRI) service.

The proposed satellite ED will be approximately 21 miles from the proposed Erlanger Sequatchie Valley Regional Hospital and will be operated under its license. Erlanger Sequatchie Valley Regional Hospital will operate as a 25 bed licensed critical access hospital.

In effect these applications swap locations (counties, not specific sites) for the parent hospital and satellite ED. The 25 bed critical access hospital located at Erlanger Bledsoe will locate to Sequatchie County and be renamed Erlanger Sequatchie Valley Regional Hospital. The current Erlanger Bledsoe Hospital emergency department (satellite of Erlanger Bledsoe Hospital) will move from Sequatchie County to Bledsoe County and be renamed to Erlanger Sequatchie Valley Regional Hospital, Satellite ED. The following chart illustrates the proposed changes.

	Current Name/ Location	**Proposed Name/ Location**
25 Bed Critical Access Hospital	**Erlanger Bledsoe Hospital** 71 Wheelertown Avenue, Pikeville (**Bledsoe County**), TN	**Erlanger Sequatchie Valley Regional Hospital** 17399 Rankin Avenue Dunlap (**Sequatchie County**), TN
Satellite Emergency Department	**Erlanger Bledsoe Hospital, Satellite ED** 17399 Rankin Avenue Dunlap (**Sequatchie County**), TN	**Erlanger Sequatchie Valley Regional Hospital, Satellite ED** 533 US Highway 127 Bypass Pikeville (**Bledsoe County**), TN

If a new replacement hospital and satellite emergency department are approved, it is anticipated the vacated Erlanger Bledsoe Hospital will be renovated and adapted for use by the Bledsoe County Nursing Home, which is currently attached to the existing hospital facility and the vacated satellite ED in Sequatchie County will be repurposed as an office suite that can be utilized by rotating physician specialists from Erlanger Medical Center in support of the new hospital which will be 0.25 miles away.

SERVICE SPECIFIC CRITERIA AND STANDARD REVIEW

CONSTRUCTION, RENOVATION, EXPANSION, AND REPLACEMENT OF HEALTH CARE INSTITUTIONS

1. **For relocation or replacement of an existing licensed health care institution:**

   a. The applicant should provide plans which include costs for both renovation and relocation, demonstrating the strengths and weaknesses of each alternative

   The applicant chose to "swap the counties" of the hospital and satellite ED to better serve the service area population now and in the future. Renovation of the current hospital was not considered an option because of the age and condition of the hospital's 46 year old physical plant.

   The only option available for the applicant is to close Erlanger Bledsoe Hospital in Pikeville (Bledsoe County), TN and establish a satellite emergency department (ED) containing 7 treatment rooms in a new modern 8,100 square foot building to be constructed on a 4 acre site 1.2 miles away located at 533 US Highway 127 Bypass, Pikeville (Bledsoe County) TN.

   It appears that this criterion has been met.

   b. The applicant should demonstrate that there is an acceptable existing or projected future demand for the proposed project.

   For 2016, the average number of emergency visits per room at Erlanger Bledsoe Hospital main campus was 1,109 (5,546 Total Visits/5 treatment rooms), or 95.2% of the ACEP low acuity guideline of 1,250 visits per treatment room for a comparable 8,250 building gross square footage (BGSF) emergency department with an annual ED volume of 10,000 visits (minimum ACEP benchmark).

   It appears that this criterion has been met.

SERVICE SPECIFIC CRITERIA AND STANDARD REVIEW

FREESTANDING EMERGENCY DEPARTMENTS

Standards and Criteria

1. **Determination of Need:** The determination of need shall be based upon the existing access to emergency services in the proposed service area. The applicant should utilize the metrics below, as well as other relevant metrics, to demonstrate that the population in the proposed service area has inadequate access to emergency services due to geographic isolation, capacity challenges, or low-quality of care.

Erlanger Bledsoe Hospital is the only existing provider of emergency medical care in the service area. There will be no change if emergency services in Bledsoe County if this application is approved.

The applicant shall provide information on the number of existing emergency department (ED) facilities in the service area, as well as the distance of the proposed FSED from these existing facilities. If the proposed service area is comprised of contiguous ZIP Codes, the applicant shall provide this information on all ED facilities located in the county or counties in which the service area ZIP Codes are located.

The proposed satellite ED is approximately 1.2 miles from the existing Erlanger Bledsoe Hospital. Erlanger Bledsoe Hospital is slated to be moved to adjoining Sequatchie County in a companion application (CN1709-027).

The applicant should utilize Centers for Medicare and Medicaid Services (CMS) throughput measures, available from the CMS Hospital Compare website, to illustrate the wait times at existing emergency facilities in the proposed service area. Data provided on the

CMS Hospital Compare website does have a three to six month lag. In order to account for the delay in this information, the applicant may supplement CMS data with other more timely data.

The applicant identified Erlanger Bledsoe Hospital as the only existing provider of emergency medical care in the service area. Please refer to the table on page 31 of the application that illustrates the wait times at Erlanger Bledsoe Hospital using CMS Hospital Compare Data.

The applicant should also provide data on the number of visits per treatment room per year for each of the existing emergency department facilities in the service area.

For 2016, the average number of emergency visits per room at the main campus of Erlanger Bledsoe Hospital was 1,109 (5,546 Total Visits/5 treatment rooms).

Applicants should utilize applicable data in the Hospital Joint Annual Report to demonstrate the total annual ED volume and annual emergency room visits of the existing facilities within the proposed service area. All existing EDs in the service area should be operating at capacity. This determination should be based upon the annual visits per treatment room at the host hospital's emergency department (ED) as identified by the American College of Emergency Physicians (ACEP) in *Emergency Department Design: A Practical Guide to Planning for the Future, Second Edition* as capacity for EDs. The capacity levels set forth by this document should be utilized as a *guideline* for describing the potential of a respective functional program. The annual visits per treatment room should exceed what is outlined in the ACEP document. Because the capacity levels set forth in the Emergency *Department Design: A Practical Guide to Planning for the Future, Second Edition* are labeled in the document as a "preliminary sizing chart", the applicant is encouraged to provide additional evidence of the capacity, efficiencies, and demographics of patients

served within the existing ED facility in order to better demonstrate the need for expansion.

The applicant indicates in 2016 Erlanger Bledsoe Hospital provided 5,546 ED visits in 5 treatment rooms. The applicant is proposing a 7 treatment room satellite ED with 8,100 square feet of space. The ACEP recommends at a minimum 7 treatment rooms with 8,250 building gross square footage (BGSF) for an emergency department with an annual ED volume of 10,000 visits. Using the ACEP methodology, the proposed satellite ED could accommodate a maximum of 10,000 ED visits per year as illustrated in the following chart.

Emergency Department Design: A Practical Guide to Planning, 2016, American College of Emergency Physicians-High and Low Estimates for dept. spaces							
Projected Annual Visit	***Dept. Gross Area***		***Space Quantities***				
	Low Range	*High Range*	*Low Range Spaces Qty.*	*Low Range capacity Visits/Space*	*High Range Space Qty.*	*High Range Capacity Visits/Space*	*Estimated Area /Space*
10,000	*8,250 dgsf*	*12,031 dgsf*	*7*	*1,250*	*8*	*909*	*875 dsgf/space*
Applicant-Erlanger Sequatchie Valley Satellite ED							
Projected Visits Yr. 1	*Total Square Footage*		*Spaces*		*Visits Per Space*		*Estimated Area /space*
5,600	*8,100*		*7*		*800*		*1,643 dsgf/space*

Note to Agency members: This application is for a satellite emergency department of a 25 bed critical access hospital in a rural county. The low range estimates of The American College of Emergency Physicians (ACEP) in Emergency Department Design: A Practical Guide to Planning for the Future, Second Edition (Guide) provides a sizing chart (as illustrated in the above chart) for emergency departments that only begins at 10,000 ED visits per year and does not target critical access hospitals. The sizing chart does not go below 10,000 ED visits per year. Given the unique nature of this

application, the 10,000 visits threshold is the only ACEP guideline available to evaluate this proposed critical access hospital satellite ED application.

It appears that this criterion has been met since the applicant will be operating in a proposed 8,100 DGSF satellite ED at a capacity of 55.46% (5,600 ED visits) of an ACEP ED recommended low-range estimate annual volume of 10,000 ED visits for a comparable 8,250 DGSF ED.

If the applicant is demonstrating low-quality care provided by existing EDs in the service area, the applicant shall utilize the Joint Commission's "Hospital Outpatient Core Measure Set". These measures align with CMS reporting requirements and are available through the CMS Hospital Compare website. Full details of these measures can be found in the Joint Commission's *Specification Manual for National Hospital Outpatient Department Quality Measures*. Existing emergency facilities should be in the bottom quartile of the state in the measures listed below in order to demonstrate low-quality of care.

N/A. The applicant is not demonstrating low-quality care provided by existing EDs in the proposed service area.

The HSDA should consider additional data provided by the applicant to support the need for the proposed FSED including, but not limited to, data relevant to patient acuity levels, age of patients, percentage of behavioral health patients, and existence of specialty modules. These data may provide the HSDA with additional information on the level of need for emergency services in the proposed service area. If providing additional data, applicants should utilize Hospital Discharge Data System data (HDDS) when applicable. The applicant may utilize other data sources to demonstrate the percentage of behavioral health patients but should explain why the alternative data source provides a more accurate indication of the percentage of behavioral health patients than the HDDS data.

The applicant did not provide additional data through the Hospital Discharge Data System (HDDS). In addition, the applicant did not utilize other data sources to demonstrate the percentage of behavioral health patients.

See Standard 2, Expansion of Existing Emergency Department Facility, for more information on the establishment of a FSED for the purposes of decompressing volumes and reducing wait times at the host hospital's existing ED.

Applicants seeking to establish an FSED in a geographically isolated, rural area should be awarded special consideration by the HSDA.

The applicant is seeking to establish an FSED in rural Bledsoe County as a result of the proposed relocation of a 25 bed critical access hospital from Bledsoe to Sequatchie County.

2. **Expansion of Existing Emergency Department Facility:** Applicants seeking expansion of the existing host hospital ED through the establishment of a FSED in order to decompress patient volumes should demonstrate the existing ED of the host hospital is operating at capacity. This determination should be based upon the annual visits per treatment room at the host hospital's emergency department (ED) as identified by the American College of Emergency Physicians (ACEP) in *Emergency Department Design: A Practical Guide to Planning for the Future, Second Edition* as capacity for EDs. The capacity levels set forth by this document should be utilized as a *guideline* for describing the potential of a respective functional program. The applicant shall utilize the applicable data in the Hospital Joint Annual Report to demonstrate total annual ED volume and annual emergency room visits. The annual visits per treatment room should exceed what is outlined in the ACEP document. Because the capacity levels set forth in the Emergency *Department Design: A Practical Guide to Planning for the Future, Second*

Edition are labeled in the document as a "preliminary sizing chart", the applicant is encouraged to provide additional evidence of the capacity, efficiencies, and demographics of patients served within the existing ED facility in order to better demonstrate the need for expansion. See Standard 1, Demonstration of Need, for examples of additional evidence.

Additionally, the applicant should discuss why expansion of the existing ED is not a viable option. This discussion should include any barriers to expansion including, but not limited to, economic efficiencies, disruption of services, workforce duplication, restrictive covenants, and issues related to access. The applicant should also provide evidence that all practical efforts to improve efficiencies within the existing ED have been made, including, but not limited to, the review of and modifications to staffing levels.

Applicants seeking to decompress volumes of the existing host hospital ED should be able to demonstrate need for the additional facility in the proposed service area as defined in the application in accordance with Standard 1, Determination of Need.

Not applicable.

3. Relationship to Existing Similar Services in the Area: The proposal shall discuss what similar services are available in the service area and the trends in occupancy and utilization of those services. This discussion shall include the likely impact of the proposed FSED on existing EDs in the service area and shall include how the applicant's services may differ from existing services. Approval of the proposed FSED should be contingent upon the applicant's demonstration that existing services in the applicant's proposed geographical service area are not adequate and/or there are special circumstances that require additional services.

Rural: The applicant should provide patient origin data by ZIP Code for each existing facility as well as the proposed FSED in order to verify the proposed facility will not negatively impact the patient base of the existing rural providers. The establishment of a FSED in a rural area should only be approved if the applicant can adequately demonstrate the proposed facility will not negatively impact any existing rural facilities that draw patients from the proposed service area. Additionally, in an area designated as rural, the proposed facility should not be located within 10 miles of an existing facility. Finally, in rural proposed service areas, the location of the proposed FSED should not be closer to an existing ED facility than to the host hospital.

Critical Access Hospitals (CAH): In Tennessee, certain CAHs are not located in rural areas according to the definition of rural provided in these standards. The location of the proposed FSED should not be closer to an existing CAH than to the host hospital.

N/A. There are no other providers of emergency services in rural Bledsoe County. The proposed FSED will be located approximately 21 miles from proposed Erlanger Sequatchie Valley Regional Hospital located at 17399 Rankin Avenue Dunlap, TN in adjoining Sequatchie County. The proposed satellite ED will be operated under the license of Erlanger Sequatchie Valley Regional Hospital, a 25 bed licensed critical-access hospital.

4. **Host Hospital Emergency Department Quality of Care:** Additionally, the applicant shall provide data to demonstrate the quality of care being provided at the ED of the host hospital. The quality metrics of the host hospital should be in the top quartile of the state in order to be approved for the establishment of a FSED. The applicant shall utilize the Joint Commission's hospital outpatient core measure set. These measures align with CMS reporting requirements and are available through the CMS Hospital Compare website. Full details of these measures can be found in the Joint Commission's *Specification Manual for*

National Hospital Outpatient Department Quality Measures.

OP-1	Median Time to Fibrinolysis
OP-2	Fibrinolytic Therapy Received Within 30 Minutes
OP-3	Median Time to Transfer to Another Facility for Acute Coronary Intervention
OP-4	Aspirin at Arrival
OP-5	Median Time to ECG
OP-18	Median Time from ED Arrival to Departure for Discharged ED Patients
OP-20	Door to Diagnostic Evaluation by a Qualified Medical Personnel
OP-21	ED-Median Time to Pain Management for Long Bone Fracture
OP-23	ED-Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients who Received Head CT or MRI Scan Interpretation With 45 Minutes of ED Arrival

The applicant provided a table on page 6 of supplemental #1 that compares the Erlanger Bledsoe Hospital's CMS reporting elements to state and national averages; however the data is not broken out by quartiles.

Since the applicant did not provide quartile information, it is unknown if the applicant is in the top quartile of the state in order to be approved for the establishment of an FSED. It is unknown as to whether this criterion has been met.

5. **Appropriate Model for Delivery of Care:** The applicant should discuss why a FSED is the appropriate model for delivery of care in the proposed service area.

The applicant notes the proposed FSED will provide greater access by serving patients closer to their homes in an improved modern facility. Community residents will also continue to have timely access to a full range of emergency medical services at Erlanger Medical Center-University Hospital inclusive of Level I trauma services for adults and children.

6. **Geographic Location:** The FSED should be located within a 35 mile radius of the hospital that is the main provider.

The proposed FSED will be located in a newly constructed 8,100 square foot (SF) single story building on a 4 acre site in Bledsoe County, approximately 21 miles northeast of Erlanger Sequatchie Valley Regional Hospital's proposed main campus in adjoining Sequatchie County.

7. **Access:** The applicant must demonstrate an ability and willingness to serve equally all of the service area in which it seeks certification. In addition to the factors set forth in HSDA Rule 0720-11-.01(1) (listing factors concerning need on which an application may be evaluated), the HSDA may choose to give special consideration to an applicant that is able to show that there is limited access to ED services in the proposed Service Area.

In 2016 Erlanger Bledsoe County served 5,546 ED patients which consisted of 4,592 patients, or 82.8% from Bledsoe County.

8. **Services to High-Need Populations:** Special consideration shall be given to applicants providing services fulfilling the unique needs and requirements of certain high-need populations, including patients who are uninsured, low income, or patients with limited access to emergency care.

The applicant will provide $935,575 in Charity Care (274 ED visits) in Year One. The facility will service all patients without regard to ability to pay.

9. **Establishment of Non-Rural Service Area:** The geographic service area shall be reasonable and based on an optimal balance between population density and service proximity of the applicant. The socio-demographics of the service area and the projected population to receive services shall be considered. The applicant shall demonstrate the orderly development of emergency services by providing

information regarding current patient origin by ZIP Code for the hospital's existing ED in relation to the proposed service area for the FSED.

Establishment of a Rural Service Area: Applicants seeking to establish a freestanding emergency department in a rural area with limited access to emergency medical care shall establish a service area based upon need. The applicant shall demonstrate the orderly development of emergency services by providing information regarding patient origin by ZIP Code for the proposed service area for the FSED.

The applicant provided a table on page 38 of Bledsoe County ED patient destination for the years 2014-2016. In 2016, Erlanger Health System maintained a market share of 76.5% of ED visits in Bledsoe County.

10. **Relationship to Existing Applicable Plans; Underserved Area and Population:** The proposal's relationship to underserved geographic areas and underserved population groups shall be a significant consideration.

The proposed FSED will accommodate pediatric and geriatric patients, and the facility will treat all patients without regard to ability to pay.

11. **Composition of Services:** Laboratory and radiology services, including but not limited to XRAY and CT scanners, shall be available on-site during all hours of operation. The FSED should also have ready access to pharmacy services and respiratory services during all hours of operation.

Laboratory, respiratory, and radiology services, including x-ray and CT will be available on-site during all hours of operation.

12. **Pediatric Care:** Applicants should demonstrate a commitment to maintaining at least a Primary Level of pediatric care at the FSED as defined by CHAPTER 1200-08- 30 Standards for Pediatric Emergency Care Facilities including staffing levels, pediatric equipment, staff training, and pediatric services. Applicants should include information detailing the expertise, capabilities, and/or training of staff to stabilize or serve pediatric patients. Additionally, applicants shall demonstrate a referral relationship, including a plan for the rapid transport, to at least a general level pediatric emergency care facility to allow for a specialized higher level of care for pediatric patients when required.

The applicant indicates Children's Hospital at Erlanger (Hamilton County) is a state designated regional pediatric center. A helipad will be available on-site at the proposed satellite ED for any needed pediatric emergency transfers via LifeForce helicopter to the Children's Hospital at Erlanger.

13. **Assurance of Resources:** The applicant shall document that it will provide the resources necessary to properly support the applicable level of emergency services. Included in such documentation shall be a letter of support from the applicant's governing board of directors or Chief Financial Officer documenting the full commitment of the applicant to develop and maintain the facility resources, equipment, and staffing to provide the appropriate emergency services. The applicant shall also document the financial costs of maintaining these resources and its ability to sustain them to ensure quality treatment of patients in the ED continuum of care.

The applicant provided a letter from the Chief Financial Officer of Erlanger Health System documenting the availability of resources and commitment to use them.

14. Adequate Staffing: An applicant shall document a plan demonstrating the intent and ability to recruit, hire, train, assess competencies of, supervise, and retain the appropriate numbers of qualified personnel to provide the services described in the application and that such personnel are available in the proposed service area. Each applicant shall outline planned staffing patterns including the number and type of physicians and nurses. Each FSED is required to be staffed by at least one physician and at least one registered nurse at all times (24/7/365). Physicians staffing the FSED should be board certified or board eligible emergency physicians. If significant barriers exist that limit the applicant's ability to recruit a board certified or board eligible emergency physician, the applicant shall document these barriers for the HSDA to take into consideration. Applicants are encouraged to staff the FSED with registered nurses certified in emergency nursing care and/or advanced cardiac life support. The medical staff of the FSED shall be part of the hospital's single organized medical staff, governed by the same bylaws. The nursing staff of the FSED shall be part of the hospital's single organized nursing staff. The nursing services provided shall comply with the hospital's standards of care and written policies and procedures.

The proposed FSED will require 19.4 total direct care patient care positions in Year One. A table of the positions is provided on page 78 of the application.

Adequate Staffing of a Rural FSED: An applicant shall document a plan demonstrating the intent and ability to recruit, hire, train, assess competencies of, supervise, and retain the appropriate numbers of qualified personnel to provide the services described in the

application and that such personnel are available in the proposed service area. Each applicant shall outline planned staffing patterns including the number and type of physicians. FSEDs proposed to be located in rural areas are required to be staffed in accordance with the Code of Federal Regulations Title 42, Chapter IV, Subchapter G, Part 485, Subpart F - Conditions of Participation: Critical Access Hospitals (CAHs). This standard requires a physician, nurse practitioner, clinical nurse specialist, or physician assistant be available at all times the CAH operates. The standard additionally requires a registered nurse, clinical nurse specialist, or licensed practical nurse to be on duty whenever the CAH has one or more inpatients. However, because FSEDs shall be in operation 24/7/365 and because they will not have inpatients, a registered nurse, clinical nurse specialist, or licensed practical nurse shall be on duty at all times (24/7/365). Additionally, due to the nature of the emergency services provided at an FSED and the hours of operation, a physician, nurse practitioner, clinical nurse specialist, or physician assistant shall be on site at all times.

The applicant notes the proposed FSED will be staffed in compliance with the Code of Federal Regulations, Title 42, Chapter IV, Subchapter G, Part 485, Subpart F - Conditions of Participation: Critical Access Hospitals (CAHs). The proposed FSED will require 19.4 total direct care patient care positions in Year One. A table of the positions is provided on page 78 of the application.

15. Medical Records: The medical records of the FSED shall be integrated into a unified retrieval system with the host hospital.

The medical records of the proposed FSED will be part of the Erlanger Health System integrated electronic medical record system.

16. **Stabilization and Transfer Availability for Emergent Cases:** The applicant shall demonstrate the ability of the proposed FSED to perform stabilizing treatment within the FSED and demonstrate a plan for the rapid transport of patients from the FSED to the most appropriate facility with a higher level of emergency care for further treatment. The applicant is encouraged to include air ambulance transport and an on-site helipad in its plan for rapid transport. The stabilization and transfer of emergent cases must be in accordance with the Emergency Medical Treatment and Labor Act.

The FSED will have a helipad for Air Transportation and a ground ambulance will be stationed within a ½ of a mile of the the proposed FSED for patient transfers. The average air transport from Bledsoe County to Erlanger Medical Center in Hamilton County is 17 minutes.

17. **Education and Signage:** Applicants must demonstrate how the organization will educate communities and emergency medical services (EMS) on the capabilities of the proposed FSED and the ability for the rapid transport of patients from the FSED to the most appropriate hospital for further treatment. It should also inform the community that inpatient services are not provided at the facility and patients requiring inpatient care will be transported by EMS to a full service hospital. The name, signage, and other forms of communication of the FSED shall clearly indicate that it provides care for emergency and/or urgent medical conditions without the requirement of a scheduled appointment. The applicant is encouraged to demonstrate a plan for educating the community on appropriate use of emergency services contrasted with appropriate use of urgent or primary care.

The applicant notes ED signage will meet all CMS standards and guidelines. The applicant delivers monthly updates regarding medical services to the community through the County Commission.

18. Community Linkage Plan: The applicant shall describe its participation, if any, in a community linkage plan, including its relationships with appropriate health and outpatient behavioral health care system, including mental health and substance use, providers/services, providers of psychiatric inpatient services, and working agreements with other related community services assuring continuity of care. The applicant is encouraged to include primary prevention initiatives in the community linkage plan that would address risk factors leading to the increased likelihood of ED usage.

The applicant is a member of the Erlanger Health System. Patients of the proposed emergency department will have access to behavioral health services through Erlanger Behavioral Health (CN1603-012) which is currently under construction. The projected completion date of the proposed project is June 2018.

Erlanger Behavioral Health, LLC will be a new 88 inpatient licensed bed psychiatric hospital located at the intersection of North Holtzclaw Avenue and Citico Avenue, Chattanooga (Hamilton County), TN. Erlanger Behavioral Health's 88 licensed beds will consist of the following inpatient units: adult (24 beds); geriatric (24 beds); children and adolescent (18 beds); and adult chemical dependency services (22 beds).

19. Data Requirements: Applicants shall agree to provide the Department of Health and/or the HSDA with all reasonably requested information and statistical data related to the operation and provision of services and to report that data in the time and format

requested. As a standard practice, existing data reporting streams will be relied upon and adapted over time to collect all needed information.

The applicant agrees to comply with data requirements.

20. Quality Control and Monitoring: The applicant shall identify and document its existing or proposed plan for data reporting, quality improvement, and outcome and process monitoring system. The FSED shall be integrated into the host hospital's quality assessment and process improvement processes.

The proposed FSED will be accredited by The Joint Commission.

The proposed FSED will be integrated into the host hospital's quality assessment and process improvement process.

21. Provider-Based Status: The applicant shall comply with regulations set forth by 42 CFR 413.65, *Requirements for a determination that a facility or an organization has provider-based status,* in order to obtain provider-based status. The applicant shall demonstrate eligibility to receive Medicare and Medicaid reimbursement, willingness to serve emergency uninsured patients, and plans to contract with commercial health insurers.

The applicant will serve all patients regardless of ability to pay and will accept patients with Medicare, Medicaid, and commercial insurance. The applicant provides a letter from CMS documenting compliance.

22. Licensure and Quality Considerations: Any applicant for this CON service category shall be in compliance with the appropriate rules of

the TDH, the EMTALA, along with any other existing applicable federal guidance and regulation. The applicant shall also demonstrate its accreditation status with the Joint Commission or other applicable accrediting agency. The FSED shall be subject to the same accrediting standards as the licensed hospital with which it is associated.

The applicant attests to the compliance with appropriate rules of the Tennessee Department of Health, The EMTALA, along with existing applicable federal guidance and regulations. Erlanger Sequatchie Valley Regional Hospital is Joint Commission accredited and the FSED will be subject to the same Joint Commission accrediting standards.

Staff Summary

The following information is a summary of the original application and all supplemental responses. Any staff comments or notes, if applicable, will be in bold italics.

Application Synopsis

The applicant is seeking Certificate of Need approval for the establishment of a satellite emergency department (ED) to be operated under the license of Erlanger Sequatchie Valley Regional Hospital. The satellite ED will be located in a newly constructed 8,100 square foot (SF) single story building on a 4 acre site in Bledsoe County, approximately 21 miles northeast of Erlanger Sequatchie Valley Regional Hospital's proposed main campus in adjoining Sequatchie County.

Erlanger Sequatchie Valley Regional Hospital's proposed satellite ED will provide a full range of Level 1- level 5 emergency care services 24 hours-a-day, 7 days a week to adult and pediatric patients as well as ancillary services, including, but not limited to, medical lab, X-Ray, CT, and ultrasound imaging services.

An overview of the project is provided in the Executive Summary on pages 4-7 of the original application. If approved, the satellite emergency department is projected to open in October 2019.

Need

- If approved, Erlanger Sequatchie Valley Regional Hospital-Satellite Emergency Department will be the only provider of emergency department services in Bledsoe County.
- The life span of existing Erlanger Bledsoe Hospital's physical plant is past its date of replacement.
- For 2016, the average number of emergency visits per room at Erlanger Bledsoe Hospital was 1,109 (5,546 Total Visits/5 treatment rooms), or 95.2% of the ACEP low acuity guideline of 1,250 visits per treatment room.

Ownership

- The applicant, Erlanger Sequatchie Valley Regional Hospital, is owned by Chattanooga-Hamilton County Hospital Authority d/b/a the Erlanger Health System.
- Erlanger Medical Center has 788 licensed hospital beds and is located at 975 East Third Avenue, Chattanooga (Hamilton County), TN that is part of the Erlanger Health System.
- Erlanger Health Systems is also associated with the Vanderbilt Health Affiliated Network.

Facility Information

- The total gross square footage (SF) of the proposed new 1-story building is 8,100 square feet. A floor plan drawing is included in the attachments to the application.
- The proposed satellite ED will contain a lab, 7 exam rooms, including 1 exam room that can be used for a secure holding/isolation room, and one trauma room. Also included in the design is one triage station, 1 decontamination station, 1 telemedicine room, separate rooms for CT, ultrasound and X-ray imaging services, and separate lounges for staff and EMS personnel..
- A main canopied entrance at the front of the building opens to patient reception and general waiting area. A covered entrance for ambulance services is located in the rear of the building.
- The applicant provided an option to lease "turnkey" agreement (that includes construction, and equipment, fixtures and furniture) with Bledsoe County for a term of 10 years with 2 successive 10 year renewal terms.
- The applicant will not station an ambulance at the proposed satellite ED. EMS services are located within 0.5 miles of the proposed FSED site.

- The proposed satellite ED will be open 24 hours/day, 7 days/week, and 365 days/year.

Erlanger Sequatchie Valley Regional Hospital Main and Satellite Emergency Department (ED) Proposed Room Configurations

Patient Care Areas other than Ancillary Services	# Current Hospital ED	# Current Satellite ED	# Current Combined EDs	# Proposed Hospital ED	# Proposed Satellite ED	# Proposed Combined EDs
Exam/Treatment Rooms	1	3	4	4	2	6
Multipurpose				3	2	5
Gynecological						
Holding/Secure/Psychiatric						
Isolation						
Orthopedic				1	1	2
Trauma	1		1		1	1
Other	3	2	5	2	4	6
Triage Stations					1	1
Decontamination Rooms/Stations					1	1
Total	5	5	10	10	12	22
Useable SF of Main and Satellite ED's	3,830	5,100	8,930	11,200	8,100	19,300

Source: CN1709-028, Supplemental #1

Service Area Demographics

Erlanger Sequatchie Valley Regional Hospital Satellite Emergency Department's declared primary service area is Bledsoe County.

- The total population of the proposed service area is estimated at 13,333 residents in calendar year (CY) 2017 increasing by approximately 1.4% to 13,516 residents in CY 2021.
- The overall Tennessee statewide population is projected to grow by 4.2% from 2017 to 2021.
- The total 65+ age population is estimated at 2,450 residents in CY 2017 increasing approximately 11.0% to 2,720 residents in 2021.
- The 65+ age population in the state of Tennessee overall is expected to increase 13.9% during the same timeframe.
- The latest 2017 percentage of the Bledsoe County population enrolled in the TennCare program is approximately 22.9% as compared to the statewide enrollment proportion of 20.5%.

Service Area Historical Utilization

The applicant's historical and projected utilization is shown in the following table:

Erlanger Sequatchie Valley and Satellite ED Historical and Projected Utilization

	Actual			Projected		
Year	**2014**	**2015**	**2016**	**Yr. 1**	**Yr.2**	**Yr. 5**
Main Campus Visits	6,105	5,341	5,546	11,000	11,220	11,907
Main Campus Rooms	5	5	5	9	9	9
Main Campus Visits/ Room	1,221.0	1,068.2	1,109.2	1,222.2	1,246.7	1,323
Satellite Visits	3,842	9,581	10,229	5,600	5,678	5,918
Satellite Rooms	5	5	5	7	7	7
Satellite Visits Per Room	768.4	1916.2	2,045.8	800.00	811.1	845.4
Total Visits	9,947	14,922	15,775	16,600	16,898	17,825
Total Rooms	10	10	10	16	16	16
Total Visits Per Room	**994.7**	**1492.2**	**1577.5**	**1,037.5**	**1,056.1**	**1.114.1**

The table above reflects the following:

- Utilization of the Erlanger Bledsoe Hospital Main ED decreased by approximately 9.1% from 6,105 ED visits in 2014 to 5,546 total ED visits in 2016.
- By Year 1 (2021) of the proposed project, the applicant expects total main ED visits to be at 11,000 at the proposed Erlanger Sequatchie Valley Regional Hospital (Sequatchie County), a 98% projected increase from 5,526 total main ED visits at Erlanger Bledsoe Hospital (Bledsoe County) in 2016.
- The applicant projects a 5.6% increase in the proposed Satellite ED's utilization from 5,600 ED visits in Year 1 (2020) to 5,918 visits in Year Five (2025).
- The combined utilization of the main ED and proposed satellite ED is expected to increase by approximately 7.4% from 16,600 total combined visits in 2020 to 17,825 visits (1,114 visits/room) in 2025.

Note to Agency members: Essentially the applicant is projecting that the ED visit volume level currently at Erlanger Bledsoe's main campus will transfer to the proposed satellite ED while the ED volume levels currently at the Erlanger Bledsoe Hospital Satellite ED will transfer to the proposed Erlanger Sequatchie Regional Hospital main campus in Sequatchie County.

Applicant's ED Utilization by Level of Care

The following table represents the main ED's (Bledsoe County) historical utilization and projected Year 1 satellite (Bledsoe County) ED utilization by level of care consistent with ***The Emergency Severity Index (ESI)*** that represents Level V (lowest acuity patient) to Level I (highest acuity patient).

Applicant's ED Utilization by severity Index level of Care

Level of Care	Main ED (Bledsoe County)	as a % of total	Satellite ED (Bledsoe County)	as a % of total
	2016		2020	
Level I (highest)	24	0.4%	23	0.4%
Level II	2,120	38.2%	2,140	38.2%
Level III	2,351	42.4%	2,370	42.3%
Level IV	967	17.4%	975	17.4%
Level V (lowest)	84	1.5%	88	1.5%
Total	**5,546**		**5,600**	

Source: CN1709-028, Supplemental 1

The table above reflects the following:

- More severe and complex clinical conditions (Levels 1 and II) are projected to account for approximately 38.6% at the proposed satellite ED Year 1.
- Lowest acuity clinical conditions (Levels IV and V) are projected to account for approximately 19% at the proposed satellite ED facilities in Year 1.

Note to Agency Members: The Emergency Severity Index (ESI) is a simple to use, five-level triage algorithm that categorizes emergency department patients by evaluating both patient acuity and resource needs. The following information is excerpts from the US Department of Human Services, Agency for Healthcare Research and Quality, Emergency Severity Index (ESI), "A Tool for Emergency Department Care, Version 4, Implementation Handbook, 2012 Edition.

Level I- Resuscitation

Patients assessed an ESI level 1 constitute 1 percent to 3 percent of all ED patients (Eitel, et. Al., 2003: Wuerz, Lilne, Witel, Travers, & Golboy, 2000; Wuerz, et. al., 2001), ESI research show that most ESI level I patients are admitted to intensive care units, while some die in the emergency department. Source: AHRQ Agency for Advancing Excellence in Health Care, pages 10-11.

Level II-Emergent

ESI level-2 Patients constitute approximately 20 percent to 30 percent of emergency department patients (Travers, et al., 2002; Wuerz, et al., 2001; Tanabe, Gimbel, et al., 2004); ESI research has shown that 50 to 60 percent of ESI level-2 patients are admitted from the ED (Wuerz, et al., 2001). Source: AHRQ Agency for Advancing Excellence in Health Care, pages 12-13.

Level III-Urgent

ESI level-3 patients make up 30 percent to 40 percent of patients seen in the emergency department (Eitel et al., 2003; Wuerz et al. 2001). ESI level 3 patients present with a chief complaint that requires an in-depth evaluation. Source: AHRQ Agency for Advancing Excellence in Health Care, page 13.

Levels IV and V (less urgent and non-urgent)

ESI level 4 and ESI level 5 make up between 20 percent and 35 percent of ED volume, perhaps even more in a community with poor primary care access. Source: AHRQ Agency for Advancing Excellence in Health Care, page 14.

Project Cost

Major costs are:

- Construction Cost-$2,453,400 or 55.9% of total cost.
- Fixed and Moveable Equipment-$1,155,000 or 26.3% of total cost.
- For other details on Project Cost, see the Project Cost Chart on page 60-R2 of the original application.
- Average total construction cost is expected to be $302.88 per square foot for new construction, which is between the median new construction cost of $289.85/SF and the 3rd quartile new construction cost of $394.94/SF of previously approved hospital projects from 2014-2016.

Statewide Hospital Construction Cost per Square Foot
2014-2016

	Renovated Construction	New Construction	Total Construction
1st Quartile	$160.66/sq. ft.	$260.18/sq. ft.	$208.97/sq. ft.
Median	$218.86/sq. ft.	$289.85/sq. ft.	$274.51/sq. ft.
3rd Quartile	$287.95/sq. ft.	$394.94/sq. ft.	$330.50/sq. ft.

Source: HSDA Applicant's Toolbox

Historical Data Chart
Project Only

- According to the Historical Data Chart Erlanger Bledsoe Hospital's current Sequatchie satellite ED experienced positive Free Cash Flow (Net Balance + Depreciation) for two of the three most recent years reported: $36,619 for 2014; ($28,322) for 2015; and $22,070 for 2016.

Total Hospital (includes current satellite ED)

- According to the Historical Data Chart Erlanger Bledsoe Hospital experienced positive Free Cash Flow (Net Balance + Depreciation) for the three most recent years reported: $745,448 for 2014; $653,510 for 2015; and $1,504,683 for 2016.

Projected Data Chart
Project Only

- 5,600 ED admissions are projected in Year 1 (2020) and 5,678 in Year 2 (2021).
- The applicant is projecting negative Free Cash Flow (Net Balance + Depreciation) equaling ($18,209) in Year 2020 decreasing to ($4,107) in Year 2021.

Total Hospital (includes Satellite ED)

- The applicant is projecting positive Free Cash Flow (Net Balance + Depreciation) for the total hospital will equal $1,297,015 in Year 2020 increasing to $1,374,957 in Year 2021.

Charges

In Year One of the proposed project, the average charge per ED visit is as follows:

Average Gross Charge

- $3,410

Average Deduction from Operating Revenue

- $2,568

Average Net Charge

- $841

Payor Mix

- The applicant indicates it has contracts with all TennCare MCOs available to its service area population: United HealthCare Community Plan (formerly AmeriChoice), TennCare Select, Blue Care, and AmeriGroup.
- The applicant's projected payor mix in Year 1 of the project is shown in the table below.

Erlanger Sequatchie Valley Regional Hospital Satellite ED
Service Payor Mix, Year 1

Payor Source	Gross Revenue Year 1	as a % of Gross Revenue Year 1
Medicare	$5,097,928	26.7%
TennCare/Medicaid	$6,644,491	34.8%
Commercial/Other	$4,677,874	24.5%
Self-Pay	$1,699,309	8.9%
Charity Care	$935,575	4.9%
Other	$3,188	0.2%
Total	$19,093,365	100%

Source: CN1709-028

Financing

The project will be funded from tax exempt bonds.

- A copy of a funding commitment letter dated September 8, 2017 from Gregg Ridley, Bledsoe County Mayor is provided in Attachment B-II-2 of the application.
- Review of the Audited Combined Financial Statements of Erlanger Health System provided in the attachments revealed cash & cash equivalents of $90,387,026, current assets of $268,949,694 and current liabilities of $104,927,579 for the fiscal year ending June 30, 2016. Based on these amounts, HSDA staff calculated a current ratio of approximately 2.56 to 1.0.

Note to Agency Members: current ratio is a measure of liquidity and is the ratio of current assets to current liabilities which measures the ability of an entity to cover its current liabilities with its existing current

assets. A ratio of 1:1 would be required to have the minimum amount of assets needed to cover current liabilities.

Staffing

The applicant's proposed Year One staffing includes the following:

Position	Existing FTEs (2017)	Projected FTEs Year One (2020)
Nurse Practitioner	3.0	3.0
Pharmacist	2.2	2.2
Rad Tech, Spec Proc	5.0	5.0
RN	9.2	9.2
Total Direct Care	19.4	19.4
Non Direct Care	22.6	22.6
Total	**42**	**42**

Note: Generally speaking, one (1) FTE is equivalent to an individual that works 2,080 regular hours.

PROVIDE HEALTHCARE THAT MEETS APPROPRIATE QUALITY STANDARDS

Licensure

- Erlanger Bledsoe Hospital is licensed by the Tennessee Department of Health.
- The most recent licensure survey was conducted on May 17, 2017.
- The applicant was notified on May 24, 2017 by the East Tennessee Regional Office, Division of Health Care Facilities, Tennessee Department of Health that no deficiencies were cited as a result of the May 17, 2017 licensure survey.

Certification

- The applicant is currently certified by Medicare and TennCare.

Accreditation

- The Joint Commission conducted an unannounced full survey from March 27, 2017 to March 29, 2017 for the purposes of assessing compliance with the Medicare conditions for critical access hospitals including swing bed services.
- The applicant is accredited by The Joint Commission effective March 30, 2017 valid up to 36 months.

Other Quality Standards

- In the first supplemental response the applicant commits to obtaining and/or maintaining the following:
  - Staffing levels comparable to the staffing chart presented in the CON application
  - Licenses in good standing
  - TennCare/Medicare certifications
  - Three years compliance with federal and state regulations
  - Has not been decertified in last three years
  - Self-assessment and external peer assessment processes
  - Data reporting, quality improvement, and outcome/process monitoring systems

CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTHCARE

Agreements

- Erlanger currently has patient transfer agreements in place with more than 70 hospitals and other providers in four states.
- A complete listing of contractual and/or working relationships of the applicant are located attachment B-III-1 the original application.

Impact on Existing Providers

- The applicant does not anticipate the proposed project will negatively impact other providers since there are no other providers in the service area.

Corporate documentation, real estate deed information, performance improvement plan, utilization review plan, and patient bill of rights are on file at the Agency office and will be available at the Agency meeting.

Should the Agency vote to approve this project, the CON would expire in three years.

CERTIFICATE OF NEED INFORMATION FOR THE APPLICANT:

There are no other Letters of Intent, denied applications, or outstanding Certificates of Need for this applicant.

Pending Applications

Erlanger Sequatchie Valley Regional Hospital-Dunlap, TN, CN1709-027, has a pending application scheduled to be heard at the December 13, 2017 Agency

meeting for the relocation and construction of a critical access hospital consisting of 25 licensed inpatient beds. The critical access hospital is currently located at 71 Wheelertown Avenue, Pikeville (Bledsoe County), TN 37367 and will be relocated to 17399 Rankin Avenue, Dunlap (Sequatchie County), TN 37327. The service area consists of Bledsoe, Grundy and Sequatchie Counties. The applicant is owned by the Chattanooga-Hamilton County Hospital Authority d/b/a Erlanger Health System. The estimated project cost is **$32,653,836**.

Erlanger Health System has financial interests in this project and the following:

Outstanding Certificates of Need

Erlanger Behavioral Health, CN1603-012A, has an outstanding Certificate of Need that will expire on September 1, 2019. The project was approved at the August 24, 2016 Agency meeting for the establishment an eighty-eight (88) bed mental health hospital located at an unaddressed site at the intersection of North Holtzclaw Avenue and Citico Avenue, Chattanooga, (Hamilton County), TN 37404. The estimated project cost is **$25,112,600**. *Project Status Update: An annual progress report dated July 3, 2017 indicates the project is on schedule with the site earthwork mostly complete, underground plumbing layout and installation underway, and structural steel procurement and fabrication on schedule.*

Children's Hospital at Erlanger and Erlanger East Hospital, CN1601-002A, has an outstanding Certificate of Need that will expire on July 1, 2019. The project was approved at the May 25, 2016 Agency meeting for the initiation of a 10 bed level 3 neonatal intensive care service, through the transfer of 10 medical/surgical beds from Erlanger Medical Center to Erlanger East Hospital located at 1755 Gunbarrel Road in Chattanooga (Hamilton County), TN 3416 and reclassification of the 10 beds as Level III Neonatal Intensive Care beds. These beds will be built in 8,805 SF of new construction resulting in a project cost in excess of $5M. The licensed bed complement of Erlanger East Hospital will increase from 113 to 123 total beds. The estimated project cost is **$7,021,555.** *Project Status: An email dated 11/17/17 from a representative of the applicant noted the first phase has begun with training of staff utilizing best practices from the Children's Hospital @ Erlanger. Construction for this project will follow staff training. However, if it is delayed, the applicant may need to request an extension for this CON.*

Chattanooga-Hamilton County Hospital Authority d/b/a Erlanger Medical Center, CN1412-048A, has an outstanding Certificate of Need that will expire on May 1, 2019. The project was approved at the March 25, 2015 Agency meeting for the acquisition of a linear accelerator and the initiation of services at Erlanger East Hospital at 1755 Gunbarrel Road, Chattanooga, TN a satellite hospital

operating under the license of Erlanger Medical Center, 975 East 3rd Street, Chattanooga (Hamilton County), Tennessee. If approved, the new linear accelerator at Erlanger East Hospital will replace a linear accelerator at Erlanger Medical Center reducing the number of linear accelerators at Erlanger Medical Center from two to one. The estimated project cost is **$10,532,562.00.** *Project Status Update: An email dated 11/17/17 from a representative of the applicant noted the expansion of Erlanger East Hospital has continued with the addition of the Cancer Center and Linear Accelerator. An extension was approved by the Agency for this CON due to environmental issues which were encountered. This phase began in July, 2017, with the beginning of construction and is scheduled to be completed by the summer of 2018.*

CERTIFICATE OF NEED INFORMATION FOR OTHER FACILITIES IN THE SERVICE AREA:

There are no Letters of Intent, denied applications, pending applications or outstanding Certificates of Need for other health care organizations in the service area proposing this type of service.

PLEASE REFER TO THE REPORT BY THE DEPARTMENT OF HEALTH, DIVISION OF HEALTH STATISTICS FOR A DETAILED ANALYSIS OF THE STATUTORY CRITERIA OF NEED, ECONOMIC FEASIBILITY, HEALTH CARE THAT MEETS APPROPRIATE QUALITY STANDARDS, AND CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE IN THE AREA FOR THIS PROJECT. THAT REPORT IS ATTACHED TO THIS SUMMARY IMMEDIATELY FOLLOWING THE COLOR DIVIDER PAGE.

PME (12/05/17)

LETTER OF INTENT

LETTER OF INTENT
TENNESSEE HEALTH SERVICES & DEVELOPMENT AGENCY

The Publication of Intent is to be published in The Bledsonian – Banner, a newspaper of general circulation in Bledsoe County, Tennessee, on or before September 7, 2017, for one day.

This is to provide official notice to the Health Services & Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 *et. seq.*, and the Rules of the Health Services & Development Agency, that Erlanger Sequatchie Valley Regional Hospital, with an ownership type of governmental, and to be managed by itself, intends to file an application for a Certificate of Need ("CON") to construct a provider based (free standing) emergency department in Pikeville, Bledsoe County, Tennessee.

This facility will replace the existing Erlanger Bledsoe Hospital – Provider Based ED, located at 16931 Rankin Avenue, Dunlap, TN 37327. The new Erlanger Sequatchie Valley Regional Hospital – Provider Based ED will be located at 553 U.S. Highway 127 Bypass, Pikeville, Bledsoe County, Tennessee, 37367, otherwise described as beginning at an iron rod set situated in the northeastern corner of the property at South 18 degrees 34 minutes 40 seconds West, 1,128.65 feet to a monument situated in the right of way of the U.S. Highway 127 Bypass; then South 17 degrees 4 minutes 0 seconds East 792.01 feet to an iron rod set; then North 17 degrees 4 minutes 0 seconds East 560.61 feet to the beginning.

A companion CON application will be filed with the Health Services & Development Agency for the new Erlanger Sequatchie Valley Regional Hospital in Dunlap, Sequatchie County, Tennessee, to replace the existing Erlanger Bledsoe Hospital located at 71 Wheelertown Avenue, Pikeville, Bledsoe County, Tennessee.

The total project cost is estimated to be $ 4,388,481.00.

The anticipated date of filing the application is September 12, 2017.

The contact person for this project is Joseph M. Winick, Sr. Vice President, Erlanger Health System, 975 East 3rd Street, Chattanooga, Tennessee, 37403, and by phone at (423) 778-7274.

Joseph M. Winick	September 6, 2017	Joseph.Winick@erlanger.org
	Date:	E-Mail:

The Letter Of Intent must be filed in triplicate and received between the first and the tenth day of the month. If the last day for filing is a Saturday, Sunday or State Holiday, filing must occur on the preceding business day. File this form at the following address:

Health Services & Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

The published Letter Of Intent must contain the following statement pursuant to T.C.A. §68-11-1607(c)(1): (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

Original Application
(COPY)

Erlanger Sequatchie Valley Regional Hospital (Pikeville)

CN1709-028

CERTIFICATE OF NEED APPLICATION

Chattanooga-Hamilton County Hospital Authority

D / B / A

Erlanger Sequatchie Valley Regional Hospital

Application To Relocate & Replace The Existing

Provider Based (Free Standing) Emergency Department From

Erlanger Bledsoe Hospital – Satellite ED
(Dunlap, Sequatchie County, TN)

To

Erlanger Sequatchie Valley Regional Hospital – Satellite ED
(Pikeville, Bledsoe County, TN)

ERLANGER HEALTH SYSTEM
Chattanooga, Tennessee

Section A

APPLICANT PROFILE

Section A: APPLICANT PROFILE

1. Name of Facility, Agency, or Institution.

Chattanooga-Hamilton County Hospital Authority
D / B / A
Erlanger Sequatchie Valley Regional Hospital -
Satellite Emergency Department
553 US Highway 127 Bypass
Pikeville, Bledsoe County, Tennessee 37367

** Site information - Approximately 10 acres +/- located in Bledsoe County, Tennessee, which begins at an iron rod set situated in the northeastern corner of the property at South 18 degrees 34 minutes 40 seconds West, 1,128.65 feet to a monument situated in the right of way of the U.S. Highway 127 Bypass; then South 17 degrees 4 minutes 0 seconds East 792.01 feet to an iron rod set; then North 17 degrees 4 minutes 0 seconds East 560.61 feet to the beginning.

Website Address - www.erlanger.org

Note: The facility's name and address **must be** the name and address of the project and **must be** consistent with the *Publication Of Intent*.

2. Contact Person Available For Responses To Questions.

Joseph M. Winick, Sr. Vice President
Planning & Business Development
Erlanger Health System
975 East 3rd Street
Chattanooga, TN 37403
(423) 778-8088
(423) 778-5776 -- FAX
Joseph.Winick@erlanger.org -- E-Mail

3. Executive Summary

A. Overview

Please provide an overview not to exceed three pages in total, explaining each numbered point.

Since 2010, a total of nine (9) rural hospitals in Tennessee have either closed outright, or, have discontinued inpatient services … including three (3) facilities in Southeast Tennessee, as follows: *(1)*

Parkridge West Hospital	Marion County
Copper Basin Medical Center	Polk County
Starr Regional (Etowah)	McMinn County

Rural populations are at risk due to limited, or no access, to essential healthcare services.

Erlanger Sequatchie Valley Regional Hospital – Satellite ED seeks approval to relocate and replace an existing provider based emergency department, from Dunlap, Sequatchie County, to Pikeville, Bledsoe County. With this CON application and the companion CON application, *Erlanger Sequatchie Valley Regional Hospital* seeks to reverse the current trend of hospital closures in Southeast Tennessee.

The need for a provider based emergency department in Pikeville, Bledsoe County, is further illustrated by the announcement on July 25, 2017, that *Textile Corporation of America* will be opening a manufacturing plant and creating 1,000 new jobs. In case of an accidental injury, the provider based emergency department will be readily accessible to this facility. A copy of the article is attached to this CON application.

CMS has already approved this project and has recognized *Erlanger Sequatchie Valley Regional Hospital* as a "necessary provider CAH" (critical access hospital). *(2)* The letter from CMS recognizes that the replacement hospital to be constructed in Sequatchie County, and the provider based ED to be constructed in Bledsoe County, as replacements for existing facilities are configured as a single provider as proposed herein. *(3)*

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1 *Rural Hospitals Across Tennessee At Risk Of Closing – Emergency At The ER.* See article and TV news report by Chris Conte at Nashville TV station WTVF on Tuesday, July 27, 2017. Retrieved from … http://www.newschannel5.com/news/emergency-at-the-er.

2 See letter of June 14, 2017, from CMS attached to this CON application.

3 See letter of February 24, 2017, to CMS from Ms. Stephanie Boynton, CEO of *Erlanger Bledsoe Hospital*, attached to this CON application.

It should be noted that members of the Medicare Payment Advisory Commission ("MedPAC") visited Erlanger Bledsoe Hospital in Pikeville, Tennessee, and it's provider based ED in Dunlap, Tennessee, on August 21-22, 2017. The purpose of the visit was to obtain a better understanding of how this critical access hospital and provider based emergency department can operate successfully when so many rural hospitals are closing. Potentially, this model may be suggested and/or extended to other critical access hospitals across the nation.

1.) *Description* - *Erlanger Bledsoe Hospital - Satellite ED* was opened in 2013 in Dunlap, Sequatchie County, Tennessee. With the relocation to *Erlanger Sequatchie Valley Regional Hospital*, it is necessary to relocate the provider based emergency department to Pikeville, Bledsoe County, Tennessee.

The replacement facility, *Erlanger Sequatchie Valley Regional Hospital - Satellite ED* will be located in Pikeville, Bledsoe County, Tennessee, about 21 miles north of *Erlanger Sequatchie Valley Regional Hospital*, as described in the companion CON application. The provider based emergency department in Dunlap, Sequatchie County, will be closed concurrently with the opening of *Erlanger Sequatchie Valley Regional Hospital*.

The objective for relocating the provider based emergency department from Sequatchie County to Bledsoe County is to foster access by placing an emergency department within a reasonable distance of the population of Bledsoe County and the surrounding area. The primary service area for *Erlanger Sequatchie Valley Regional Hospital - Satellite ED is Bledsoe County, Tennessee*. Thus, patients will not need to travel to the replacement hospital in Dunlap, Sequatchie County, for needed emergency services. However, patients from other surrounding counties may utilize this facility as well.

2.) *Ownership Structure* - The provider based emergency department in Bledsoe County will be

owned by *Bledsoe County* and leased to *Erlanger*. The regional hospital in Sequatchie County, described in the companion CON application, will be owned by *Sequatchie County* and leased to *Erlanger*. Both of these locations are linked together to provide needed healthcare services, and to provide a stable reimbursement structure to ensure sustainability. (See note 3)

3.) *Service Area* – *Erlanger Sequatchie Valley Regional Hospital – Satellite ED* will foster access to a centrally located emergency service in Bledsoe County. The service area for the provider based ED in Pikeville, will be primarily Bledsoe County, however, patients from other surrounding counties may utilize this facility as well.

4.) *Existing Similar Service Providers* – Within the defined service area of Bledsoe County, there are no other existing service providers for ED services.

5.) *Project Cost* – The total project cost for the replacement hospital and provider based emergency department together is $ 36,988,230, with total construction cost of $ 22,411,900. The cost for the replacement ED is only $ 4,388,481, with construction cost of $ 2,453,400, which yields a construction cost per square foot of $302.88, which is above the median SF cost of $289.85, but well below the 3rd Quartile SF cost of $395.94, for new construction.

6.) *Funding* – Funding for *Erlanger Sequatchie Valley Regional Hospital – Satellite ED* will be provided by *Bledsoe County, Tennessee*.

7.) *Financial Feasibility (including when the proposal will realize a positive financial margin)* – The proposed project will operate at breakeven, with the possibility of a slight negative margin beginning in year one. Please see the *Projected Data Chart*. However, it should be noted that the provider based ED and the

replacement hospital, as described in the companion CON application, are configured as a single hospital entity as per CMS approval … in order to sustain the facility from a financial perspective, in must be part of a critical access hospital. The combined project shows a positive margin in year 1 and year 2.

8.) *Staffing* - It is anticipated that there will be a total of forty-two (42) employees at *Erlanger Sequatchie Valley Regional Hospital – Satellite ED*. Employees of *Erlanger Bledsoe Hospital*, will be offered employment at the new provider based ED and the new regional hospital.

B. Overview

A certificate of need can only be granted when a project is necessary to provide needed health care in the area to be served, can be economically accomplished and maintained, will provide healthcare that meets appropriate quality standards, and will contribute to the orderly development of adequate and effective health care in the service area. This section should provide rationale for each criterion using the data and information points provided in section B of this application. Please summarize in one page or less each of the criteria.

Since 2010, a total of nine (9) rural hospitals in Tennessee have either closed outright, or, have discontinued inpatient services … including three (3) facilities in Southeast Tennessee, as follows: *(4)*

Parkridge West Hospital	Marion County
Copper Basin Medical Center	Polk County
Starr Regional (Etowah)	McMinn County

Rural populations are at risk due to limited, or no access, to essential healthcare services.

Erlanger Sequatchie Valley Regional Hospital – Satellite ED seeks approval to relocate and replace an

4 *Rural Hospitals Across Tennessee At Risk Of Closing – Emergency At The ER.* See article and TV news report by Chris Conte at Nashville TV station WTVF on Tuesday, July 27, 2017. Retrieved from … http://www.newschannel5.com/news/emergency-at-the-er.

existing provider based emergency department, from Dunlap, Sequatchie County, to Pikeville, Bledsoe County. With this CON application and the companion CON application, *Erlanger Sequatchie Valley Regional Hospital* seeks to reverse the current trend of hospital closures in Southeast Tennessee.

CMS has already approved this project and has recognized *Erlanger Sequatchie Valley Regional Hospital* as a "necessary provider CAH" (critical access hospital).*(5)* The letter from CMS recognizes that the replacement hospital to be constructed in Sequatchie County, and the provider based ED to be constructed in Bledsoe County, as replacements for existing facilities are configured as a single provider as proposed herein.*(6)*

It should be noted that members of the Medicare Payment Advisory Commission ("MedPAC") visited Erlanger Bledsoe Hospital in Pikeville, Tennessee, and it's provider based ED in Dunlap, Tennessee, on August 21-22, 2017. The purpose of the visit was to obtain a better understanding of how this critical access hospital and provider based emergency department can operate successfully when so many rural hospitals are closing. Potentially, this model may be suggested and/or extended to other critical access hospitals across the nation.

1.) *Need* - There will be no change in the availability of emergency services in Bledsoe County with approval of this CON application. *Erlanger Bledsoe Hospital* is the only provider of emergency department services in the service area.

The physical plant deficiencies at *Erlanger Bledsoe Hospital* necessitate that the facility be replaced. For 2016, the average number of emergency visits per room at *Erlanger Bledsoe Hospital* was 1,136 vs. the ACEP (*American College of Emergency Physicians*) low acuity standard (low range estimate) of 1,250 visits per room and the high acuity standard (high range estimate) of 909 visits per room.

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5 See letter of June 14, 2017, from CMS attached to this CON application.

6 See letter of February 24, 2017, to CMS from Ms. Stephanie Boynton, CEO of *Erlanger Bledsoe Hospital*, attached to this CON application.

2.) *Economic Feasibility* - The proposed project will operate at breakeven, with the possibility of a slight negative margin beginning in year one. Please see the *Projected Data Chart*. However, it should be noted that the provider based ED and the replacement hospital, as described in the companion CON application, are configured as a single hospital entity as per CMS approval … in order to sustain the facility from a financial perspective, it must be part of a critical access hospital. The combined project shows a positive margin in year 1 and year 2.

3.) *Appropriate Quality Standards* - *Erlanger Bledsoe Hospital* and it's existing provider based ED are currently accredited by *The Joint Commission*. They also participate in the quality reporting and monitoring program through *Erlanger Health System*. The quality reporting and monitoring will continue with *Erlanger Sequatchie Valley Regional Hospital* and it's provider based ED.

4.) *Orderly Development* - This project represents orderly development of the healthcare system. It seeks to relocate an existing critical access hospital and it's provider based ED, which are linked to performance of the broader healthcare system of care delivery in such a manner, as to place each facility where maximum access can occur for the rural population which has the most need, while also ensuring financial sustainability.

It will also provide healthcare facilities which meet "current" spatial requirements for the services to be offered. Please keep in mind that the facility for *Erlanger Bledsoe Hospital* was built in 1971 and is now forty-six (46) years old. The existing physical plant has outlived it's useful life as an acute care hospital.

C.) Consent Calendar Justification

If Consent Calendar is requested, please provide the rationale for an expedited review.

A request for Consent Calendar must be in the form of a written communication to the Agency's Executive Director at the time the application is filed.

Response

*** Not Applicable. ***

4. **A. Owner of the Facility, Agency, or Institution.**

Chattanooga-Hamilton County Hospital Authority
D / B / A
Erlanger Health System
975 East 3rd Street
Hamilton County
Chattanooga, TN 37403

B. Type of Ownership or Control (*Check One*).

A.	Sole Proprietorship	
B.	Partnership	
C.	Limited Partnership	
D.	Corporation (For Profit)	
E.	Corporation (Not-for-Profit)	
F.	Governmental (State of TN or Political Subdivision)	X
G.	Joint Venture	
H.	Limited Liability Company	
I.	Other (Specify)	

ATTACH a copy of the partnership agreement, or corporate charter and certificate of corporate existence. Please provide documentation of the active status of the entity from the Tennessee Secretary of State's web-site at https://tnbear.tn.gov/ECommerce/Filingearch.aspx. **Attachment Section A-4A.**

***Describe** the existing or proposed ownership structure of the applicant, including an ownership structure organizational chart. Explain the corporate structure and the manner in which all entities of the ownership structure relate to the applicant. As applicable, identify the members with 5% ownership interest (direct or indirect).*

5. **Name of Management / Operating Entity (if applicable).**

*** Not Applicable. ***

For new facilities or existing facilities *without a current management agreement, attach a copy of a draft management agreement that at least includes the anticipated scope of management services to be provided, the anticipated term of the agreement, and the anticipated management fee payment methodology and schedule. For facilities with existing management agreements, attach a copy of the fully executed final contract.* **Attachment Section A-5.**

6. **A. Legal Interest in the Site of the Institution**
(Check One)

A.	Ownership	____
B.	Option to Purchase	____
C.	Lease of _____ Years	____
D.	Option to Lease	X
E.	Other (Specify)	____

Check appropriate line above: *For applicant or applicant's parent company/owner that currently own the building/land for the project location, attach a copy of the title/deed. For applicant or applicant's parent company/owner that currently lease the building/land for the project location, attach a copy of the fully executed lease agreement. For projects where the location of the project has not been secured, attach a fully executed document including Option To Purchase Agreement, Option To Lease Agreement, or other appropriate documentation. Option To Purchase Agreements* ***must include*** *anticipated purchase price. Lease/Option To Lease Agreements* ***must include*** *the actual/anticipated term of the agreement* ***and*** *actual/anticipated lease expense. The legal interests described herein* ***must be valid*** *on the date of the Agency's consideration of the certificate of need application.*

B. Attach **a copy of the site's plot plan, floor plan, and if applicable, public transportation route to and from the site** on an 8 ½" x 11" sheet of white paper, single or double sided. ***DO NOT SUBMIT BLUEPRINTS***. Simple line drawings should be submitted and need not be drawn to scale.

1.) Plot Plan **must include:**

a.) Size of site (**in acres**);

Response

The size of the hospital site in Pikeville, Bledsoe County, is approximately 10 acres.

A copy of the site plan for *Erlanger Sequatchie Valley Regional Hospital – Satellite ED* is attached to this CON application.

b.) Location of structure on the site;

Response

In Pikeville, the provider based ED as described, will be placed on the northeastern section of the site, nearest to Tennessee Highway 127.

c.) Location of the proposed construction / renovation; and

Response

** *Not Applicable.* **

d.) Names of streets, roads or highway that cross or border the site.

Response

In Pikeville, the provider based ED as Described, will be located on Tennessee Highway 127.

2.) Attach a floor plan drawing for the facility which includes legible labeling of patient care rooms (noting private or semi-private), ancillary areas, equipment areas, etc. On an 8 ½ by 11 sheet of paper or as many necessary to illustrate the floor plan.

Response

Copies of the floor plans for *Erlanger Sequatchie Valley Regional Hospital – Satellite ED* in Pikeville, Bledsoe County, are attached to this CON application.

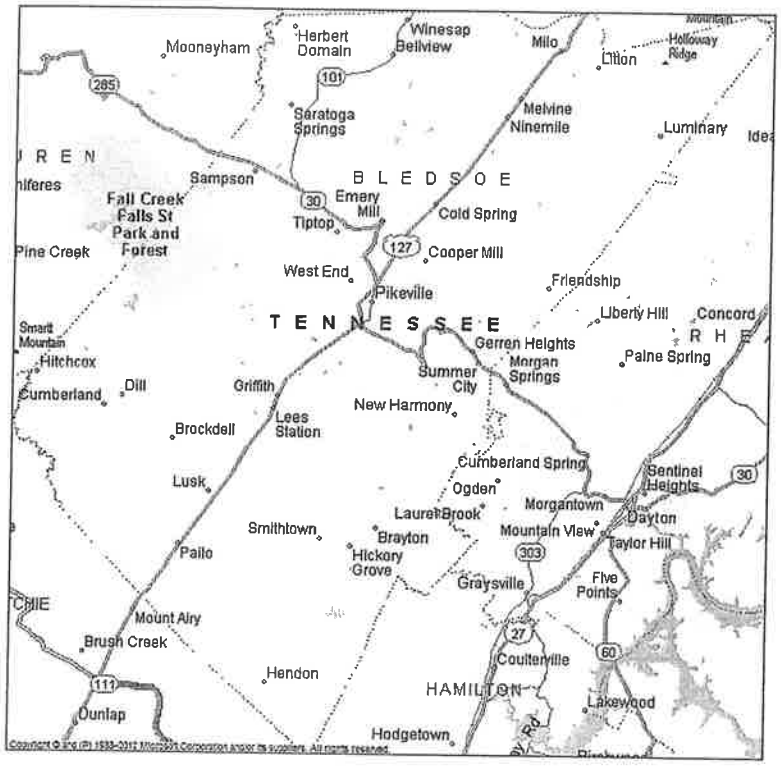
3.) Describe the relationship of the site to public transportation routes, if any, and to any highway or major road developments in the area. Describe the accessibility of the proposed site to patients/clients.

Response

The *Erlanger Sequatchie Valley Regional Hospital – Satellite ED* will serve primarily Bledsoe County, Tennessee, although patients from other counties will also utilize the facility. Public transportation is not available in Bledsoe County.

Accessibility to the satellite ED is through the use of publicly available roads, the distance to Pikeville, Tennessee, from various points in Bledsoe County is shown below.

City	Location	Miles
Milo	North	11.5 miles
Pailo	South	12.8 miles
Summer City	East	9.1 miles
Sampson	West	8.3 miles



Attachment Section A-6A, 6B-1 a-d, 6B-2, 6B-3.

7. **Type of Institution**

(Check as appropriate - more than one response may apply)

A.	Hospital (Specify) _____	
B.	Ambulatory Surgical Treatment Center (ASTC), Multi-Specialty	
C.	ASTC, Single Specialty	
D.	Home Health Agency	
E.	Hospice	
F.	Mental Health Hospital	
G.	Intellectual Disability / Institutional Habilitation Facility ICF / IID	
H.	Nursing Home	
I.	Outpatient Diagnostic Center	
J.	Rehabilitation Facility	
K.	Residential Hospice	
L.	Non-Residential Substitution-Based Treatment Center For Opiate Addiction	
M.	Other (Specify) Provider Based Emergency Dept. (*)	X

(*) Described in companion CON application, concurrently filed.

8. Purpose of Review

(Check appropriate line(s) appropriate - more than one response may apply)

A.	New Institution	
B.	Modifying an ASTC With Limitation Still Required Per CON	
C.	Addition Of MRI Unit	
D.	Pediatric MRI	
E.	Initiation of Health Care Service As Defined In TCA § 68-11-1607(a)(4) (Specify)	
F.	Change In Bed Complement [*Please note the type of change by underlining the appropriate response:* Increase, Decrease, Designation, Distribution, Conversion, Relocation]	
G.	Satellite Emergency Dept.	
H.	Change Of Location	X
I.	Other (Specify)	

9. Medicaid / TennCare, Medicare Participation

MCO Contracts [Check all that apply]

X	AmeriGroup	X	United Healthcare Community Plan
X	BlueCare	X	TennCare Select

Medicare Provider Number 044-1306
Medicaid Provider Number 044-1306
Certification Type General Medical / Surgical

If a new facility, will certification be sought for Medicare and/or Medicaid/TennCare ?

Medicare	___	**Yes**	___	**No**	**X**	**N/A**
Medicaid / TennCare	___	**Yes**	___	**No**	**X**	**N/A**

10. Bed Complement Data

A. Please indicate current and proposed distribution and certification of facility beds.

		Current Licensed	*Beds Staffed*	*Beds Proposed*	*(*)Beds Approved*	*(**)Beds Exempted*	*TOTAL Beds at Completion*
1.)	Medical						
2.)	Surgical						
3.)	ICU / CCU						
4.)	Obstetrical						
5.)	NICU						
6.)	Pediatric						
7.)	Adult Psychiatric						
8.)	Geriatric Psychiatric						
9.)	Child / Adolescent Psychiatric						
10.)	Rehabilitation						
11.)	Adult Chemical Dependency						
12.)	Child / Adolescent Chemical Depend.						
13.)	Long Term Care Hospital						
14.)	Swing Beds	25	25	25			25
15.)	Nursing Home – SNF (Medicare only)						
16.)	Nursing Home – NF (Medicaid only)						
17.)	Nursing Home – SNF / NF (dually certified M'care/M'caid)						
18.)	Nursing Home – Licensed (non-certified)						
19.)	ICF / IID						
20.)	Residential Hospice						
	TOTAL	25	25	25			25

(*) Beds approved but not yet in service. (**) Beds exempted under 10% per 3 year provision.

B. Describe the reasons for change in bed allocations and describe the impact the bed change will have on the applicant facility's existing services. **Attachment Section A-10.**

Response

*** Not Applicable. ***

A. Please identify all the applicant's outstanding Certificate of Need projects that have a licensed bed change component. If applicable, complete chart below.

CON Number	CON Expiration Date	Total Licensed Beds Approved

11. **Home Healthcare Organizations** – Home Health Agency, Hospice Agency (excluding Residential Hospice), identify the following by checking all that apply:

	Existing Licensed County	Patient Office County	Proposed Licensed County		Existing Licensed County	Patient Office County	Proposed Licensed County
Anderson	☐	☐	☐	Lauderdale	☐	☐	☐
Bedford	☐	☐	☐	Lawrence	☐	☐	☐
Benton	☐	☐	☐	Lewis	☐	☐	☐
Bledsoe	☐	☐	☐	Lincoln	☐	☐	☐
Blount	☐	☐	☐	Loudon	☐	☐	☐
Bradley	☐	☐	☐	McNairy	☐	☐	☐
Campbell	☐	☐	☐	Macon	☐	☐	☐
Cannon	☐	☐	☐	Madison	☐	☐	☐
Carroll	☐	☐	☐	Marion	☐	☐	☐
Carter	☐	☐	☐	Marshall	☐	☐	☐
Cheatham	☐	☐	☐	Maury	☐	☐	☐
Chester	☐	☐	☐	Meigs	☐	☐	☐
Claiborne	☐	☐	☐	Monroe	☐	☐	☐
Clay	☐	☐	☐	Montgomery	☐	☐	☐
Cocke	☐	☐	☐	Moore	☐	☐	☐
Coffee	☐	☐	☐	Morgan	☐	☐	☐
Crockett	☐	☐	☐	Obion	☐	☐	☐
Cumberland	☐	☐	☐	Overton	☐	☐	☐
Davidson	☐	☐	☐	Perry	☐	☐	☐
Decatur	☐	☐	☐	Pickett	☐	☐	☐
DeKalb	☐	☐	☐	Polk	☐	☐	☐
Dickson	☐	☐	☐	Putnam	☐	☐	☐
Dyer	☐	☐	☐	Rhea	☐	☐	☐
Fayette	☐	☐	☐	Roane	☐	☐	☐
Fentress	☐	☐	☐	Robertson	☐	☐	☐
Franklin	☐	☐	☐	Rutherford	☐	☐	☐
Gibson	☐	☐	☐	Scott	☐	☐	☐
Giles	☐	☐	☐	Sequatchie	☐	☐	☐
Grainger	☐	☐	☐	Sevier	☐	☐	☐
Greene	☐	☐	☐	Shelby	☐	☐	☐
Grundy	☐	☐	☐	Smith	☐	☐	☐
Hamblen	☐	☐	☐	Stewart	☐	☐	☐
Hancock	☐	☐	☐	Sullivan	☐	☐	☐
Hardeman	☐	☐	☐	Sumner	☐	☐	☐
Hardin	☐	☐	☐	Tipton	☐	☐	☐
Hawkins	☐	☐	☐	Trousdale	☐	☐	☐
Haywood	☐	☐	☐	Unicoi	☐	☐	☐
Henderson	☐	☐	☐	Union	☐	☐	☐
Henry	☐	☐	☐	Van Buren	☐	☐	☐
Hickman	☐	☐	☐	Warren	☐	☐	☐
Houston	☐	☐	☐	Washington	☐	☐	☐
Humphreys	☐	☐	☐	Wayne	☐	☐	☐
Jackson	☐	☐	☐	Weakley	☐	☐	☐
Jefferson	☐	☐	☐	White	☐	☐	☐
Johnson	☐	☐	☐	Williamson	☐	☐	☐
Knox	☐	☐	☐	Wilson	☐	☐	☐
Lake	☐	☐	☐				

12. Square Footage And Cost Per Square Foot Chart

Unit / Department	*Existing Location*	*Existing SF*	*Temporary Location*	*Proposed Final Location*	*Proposed Final Square Footage*		
					Renovated	*New*	*Total*
Emergency Dept.						8,100	8,100
Nursing – Medical/Surgical							
Admin./Admiting							
Imaging							
Surgery							
Pharmacy							
Laboratory							
Dietary							
Respiratory & PT							
Plant Ops/Circulation							
Unit/Department GSF Sub-Total						8,100	8,100
Other GSF Total							
GSF Total						8,100	8,100
(*) Total Cost						$ 2,453,400	$ 2,453,400
(**) Cost Per Square Foot						$ 302.88	$ 302.88

Cost Per Square Foot Is Within Which Range (*For quartile ranges, please refer to the Applicant's Toolbox On www.tn.gov/hsda*)			
	☐ Below 1st Quartile	☐ Below 1st Quartile	☐ Below 1st Quartile
	☐ Between 1st And 2nd Quartile	☐ Between 1st And 2nd Quartile	☐ Between 1st And 2nd Quartile
	☐ Between 2nd And 3rd Quartile	☒ Between 2nd And 3rd Quartile	☒ Between 2nd And 3rd Quartile
	☐ Above 3rd Quartile	☐ Above 3rd Quartile	☐ Above 3rd Quartile

(*) The Total Construction Cost should equal the Construction Cost reported on line A5 of the Project Cost Chart.

(**) Cost Per Square foot is the construction cost divided by the square feet. Please do not include contingency costs.

13. MRI, PET and/or Linear Accelerator

1.) Describe the acquisition of magnetic Resonance Imaging (MRI) scanner that is adding an MRI scanner in counties with population less than 250,000 or initiation of pediatric MRI in counties with population greater than 250,000, and/or

Response

*** Not Applicable. ***

2.) Describe the acquisition of any Positron Emission Tomographer (PET) or Linear Accelerator if initiating the service by responding to the following:

A.) Complete the chart below for acquired equipment.

☐ Linear Accelerator	MEV _____	Types: ☐ SRS ☐ IMRT ☐ IGRT ☐ Other _____	
	Total Cost(*): _____	☐ By Purchase	
	☐ New ☐ Refurbished	☐ By Lease -- Expected Useful Life (Yrs) ____	
		☐ If not new, how old ? (Yrs) ____	
☐ MRI	Tesla _____	Magnet: ☐ Breast ☐ Extremity	
		☐ Open ☐ Short Bore ☐ Other _____	
	Total Cost(*): _____	☐ By Purchase	
	☐ New ☐ Refurbished	☐ By Lease -- Expected Useful Life (Yrs) ____	
		☐ If not new, how old ? (Yrs) _____	
☐ PET	☐ PET Only ☐ PET / CT	☐ PET / MRI	
		☐ By Purchase	
	Total Cost(*): _____	☐ By Lease -- Expected Useful Life (Yrs) ____	
	☐ New ☐ Refurbished	☐ If not new, how old ? (Yrs) ____	

(*) As defined by Agency Rule 0720-9-.01(13)

Response

** Not Applicable. **

B.) In the case of equipment purchase, include a quote and/or proposal from an equipment

vendor. In the case of equipment lease, provide a draft lease or contract that at least includes the term of the lease and the anticipated lease payments along with the fair market value of the equipment.

Response

** Not Applicable. **

C.) Compare lease cost of the equipment to it's fair market value. Note: Per Agency rule, the higher cost must be identified in the project cost chart.

Response

** Not Applicable. **

D.) Schedule of Operations:

Location	Days Of Operation (Sunday Through Saturday)	Hours Of Operation (Example: 8 am - 3 pm)
Fixed Site (*Applicant*)		
Erlanger Sequatchie Valley Hosp.		
Erlanger Bledsoe ED	Sunday - Saturday	7 am – 6:59 am (24 Hours)
Mobile Locations		
(*Applicant*)	N / A	
(*Name Of Other Location*)		
(*Name Of Other Location*)		

E.) Identify the clinical applications to be provided that apply to the project.

Response

** Not Applicable. **

F.) If the equipment has been approved by the FDA within the last 5 years, provide documentation of the same.

Response

*** Not Applicable. ***

Section B

GENERAL CRITERIA FOR CERTIFICATE OF NEED

Section B: GENERAL CRITERIA FOR CERTIFICATE OF NEED

In accordance with Tennessee Code Annotated § 68-11-1609(b), "no Certificate of Need shall be granted unless the action proposed in the application is necessary to provide needed health care in the area to be served, can be economically accomplished and maintained, will provide healthcare that meets appropriate quality standards, and will contribute to the orderly development of health care." Further standards for guidance are provided in the state health plan (Guidelines For Growth), developed pursuant to Tennessee Code Annotated § 68-11-1625.

The following questions are listed according to the four (4) criteria: (1) Need, (2) Economic Feasibility, (3) Applicable Quality Standards, and (4) Contribution to the Orderly Development of Healthcare. Please respond to each question and provide underlying assumptions, data sources, and methodologies when appropriate. *Please type each question and its response on 8 ½" x 11" white paper, single sided or double sided.* All exhibits and tables must be attached to the end of the application in correct sequence identifying the question(s) to which they refer, unless specified otherwise. **If a question does not apply to your project, indicate "Not Applicable (NA)".**

CONSTRUCTION, RENOVATION, EXPANSION, AND REPLACEMENT OF HEALTH CARE INSTITUTIONS

[Standards & Criteria, Effective - 2000, p. 23]

1. **Any project that includes the addition of beds, services, or medical equipment will be reviewed under those specific activities.**

   Response

   **** Not Applicable. ****

2. **For relocation or replacement of an existing licensed health care institution:**

a. The applicant should provide plans which include costs for both renovation and relocation, demonstrating the strengths and weaknesses of each alternative.

Response

Erlanger Bledsoe Hospital was originally built in 1971 in Pikeville, Bledsoe County, Tennessee. At the present time, the hospital is forty-six (46) years old and in need of significant renovation and updates to meet current standards. Maintenance is ongoing and requires a significant effort to sustain operation of the hospital. The physical plant of the Erlanger Bledsoe Hospital has outlived it's useful life. It is time to replace this 25 bed critical access hospital, which has been designated by the State of Tennessee as a *necessary provider.*

The replacement facility for emergency medical services, *Erlanger Sequatchie Valley Regional Hospital – Satellite ED* will be located in Pikeville, Bledsoe County, Tennessee, approximately 21 miles from the exiting facility. The hospital based Emergency Department, in Dunlap, Sequatchie County, which was opened in 2013, will be closed with the opening of *Erlanger Sequatchie Valley Regional Hospital – Satellite ED. Erlanger Bledsoe Hospital* in Pikeville, Bledsoe County, Tennessee, will be closed with the opening of *Erlanger Sequatchie Valley Regional Hospital.*

The objective for relocating the provider based ED from Sequatchie County is to foster access by assuring that emergency medical services continue to be available in Bledsoe County, Tennessee. Thus, patients will not need to travel to *Erlanger Sequatchie Valley Regional Hospital* in Dunlap, Tennessee, or elsewhere, for this needed health service.

Renovation of *Erlanger Bledsoe Hospital* was considered. However, the facility has outlived it's usefule life, the age and condition of the physical plant are such that it is simply not practical to renovate. Current standards for space requirements are significantly different than what was applicable in 1971. The facility is also located in a residential area and is not readily accessible.

b. The applicant should demonstrate that there is an acceptable existing or projected future demand for the proposed project.

Response

There will be no change in the availability of emergency services in Bledsoe County with approval of this CON application. *Erlanger Bledsoe Hospital* is the only provider of emergency department services care in the service area.

The physical plant deficiencies at *Erlanger Bledsoe Hospital* necessitate that the facility be replaced. For 2016, the average number of emergency visits per room at *Erlanger Bledsoe Hospital* was 1,136 vs. the ACEP (American College of Emergency Physicians) low acuity standard (low range estimate) of 1,250 visits per room and the high acuity standard (high range estimate) of 909 visits per room.

3. For renovation or expansions of an existing licensed health care institution:

a. The applicant should demonstrate that there is an acceptable existing demand for the proposed project.

Response

*** Not Applicable. ***

b. The applicant should demonstrate that the existing physical plant's condition warrants major renovation or expansion.

Response

*** Not Applicable. ***

[End Of Responses To Construction, Renovation, Expansion, And Replacement Of Health Care Institutions, 2000, page 23]

FREESTANDING EMERGENCY DEPARTMENTS

[Standards & Criteria, 2016 Update To Tennessee State Health Plan]

1. Determination Of Need: The determination of need shall be based upon the existing access to emergency services in the proposed service area. The applicant should utilize the metrics below, as well as other relevant metrics, to demonstrate that the population in the proposed service area has inadequate access to emergency services due to geographic isolation, capacity challenges, or low-quality of care. The applicant shall provide information on the number of existing emergency department (ED) facilities in the service area, as well as the distance of the proposed FSED from these existing facilities. If the proposed service area is comprised of contiguous ZIP Codes, the applicant shall provide this information on all ED facilities located in the county or counties in which the service area ZIP Codes are located. The applicant should utilize Centers for Medicare and Medicaid Services (CMS) throughput measures, available from the CMS Hospital Compare website, to illustrate the wait times at existing emergency facilities in the proposed service area. Data provided on the CMS Hospital Compare website does have a three to six month lag. In order to account for the delay in this information, the applicant may supplement CMS data with other more timely data. The applicant should also provide data on the number of visits per treatment room per year for each of the existing emergency department facilities in the service area. Applicants should utilize applicable data in the Hospital Joint Annual Report to demonstrate the total annual ED volume and annual emergency room visits of the existing facilities within the proposed service area. All existing EDs in the service area should be operating at capacity. This determination should be based upon the annual visits per treatment room at the host hospital's emergency department (ED) as identified by the American College of Emergency Physicians (ACEP) in Emergency Department Design: A Practical Guide to Planning for the Future, Second Edition as capacity for EDs. The capacity levels set forth by this document should be utilized as a guideline for describing the potential of a respective functional program. The annual visits per

treatment room should exceed what is outlined in the ACEP document. Because the capacity levels set forth in the Emergency Department Design: A Practical Guide to Planning for the Future, Second Edition are labeled in the document as a "preliminary sizing chart", the applicant is encouraged to provide additional evidence of the capacity, efficiencies, and demographics of patients served within the existing ED facility in order to better demonstrate the need for expansion.

ED-1 Median time from ED arrival to ED departure for ED admitted patients
ED-2 Median time from admit decision to departure for ED admitted patients
OP-18 Median time from ED arrival to ED departure for discharged ED patients
OP-20 Door to diagnostic evaluation by a qualified medical professional
OP-22 ED-patient left without being seen

Source:
https://www.medicare.gov/hospitalcompare/search.html
https://data.medicare.gov/data/hospital-compare

Note: The above measures are found in the category "Timely and Effective Care".

If the applicant is demonstrating low-quality care provided by existing EDs in the service area, the applicant shall utilize the Joint Commission's "Hospital Outpatient Core Measure Set". These measures align with CMS reporting requirements and are available through the CMS Hospital Compare website. Full details of these measures can be found in the Joint Commission's Specification Manual for National Hospital Outpatient Department Quality Measures. Existing emergency facilities should be in the bottom quartile of the state in the measures listed below in order to demonstrate low-quality of care.

OP-1 Median Time to Fibrinolysis
OP-2 Fibrinolytic Therapy Received Within 30 Minutes
OP-3 Median Time to Transfer to Another Facility for Acute Coronary Intervention
OP-4 Aspirin at Arrival OP-5 Median Time to ECG
OP-18 Median Time from ED Arrival to Departure for Discharged ED Patients

adequate volumes to evaluate) applicants may omit these metrics from the application. However, the application should then discuss the limitations and reasoning for omission. Applicants are encouraged to supplement the listed metrics with additional metrics that may provide HSDA with a more complete representation of the need for emergency care services in the proposed service area.

Response

There will be no change in the availability of emergency services in Bledsoe County with approval of this CON application. *Erlanger Bledsoe Hospital* is the only existing provider of emergency medical care in the service area.

The physical plant deficiencies at *Erlanger Bledsoe Hospital* require that the facility be replaced. For 2016, the average number of emergency visits per room at *Erlanger Bledsoe Hospital* was 1,136 visits vs. the ACEP (American College of Emergency Physicians) low acuity standard (low range estimate) of 1,250 visits per room and the high acuity standard (high range estimate) of 909 visits per room. At the same time, the provider based emergency department in Sequatchie County has outgrown its facilities when utilization and capacity are considered … 2,097 visits per room in 2016, compared to the low acuity standard of 1,250 visits per room and the high acuity standard of 909 visits per room.

A companion CON application describes Erlanger Sequatchie Valley Regional Hospital to be located in Dunlap, Sequatchie Valley, Tennessee. CMS has indicated that its approval presumes the replacement and relocation of the hospital and provider based emergency department will be the same as currently provided (copy of CMS letter attached to this CON application). In Bledsoe County, the emergency department will move approximately 1.2 miles. No other changes are contemplated.

Metrics for *Erlanger Bledsoe Hospital* are attached to this CON application. As noted, metrics for *Erlanger Bledsoe Hospital* compare favorably with State and National averages, though in several instances *Erlanger Bledsoe Hospital* outperforms other hospitals at both the state and national level. For example, metrics related to

communications with nurses and doctors. For emergency department specific metrics, *Erlanger Bledsoe Hospital* has better times on ED transfers and treatment. Although operating statistics for the provider based emergency department are operationally integrated into *Erlanger Bledsoe Hospital*, separate operating statistics are not maintained. CMS considers the hospital and provider based emergency department to be one in the same, effectively inseparable.

Pertaining to the operating metrics identified within this criterion, data is not available for many indicators on the *Medicare Hospital Compare* website. However, data is available for a few of the indicators, as listed here:

Ind.	*Description*	*Value*
OP-4	Aspirin At Arrival	99 %
OP-18	Median Time From ED Arrival To Departure For Discharged ED Patients	95 min.
OP-20	Door To Diagnostic Eval	25 min.
OP-21	Median Time To Pain Med	49 min.
OP-22	Left Before Being Seen	2 %

A copy of the Medicare Hospital Compare data is attached to this CON application.

2. **Expansion of Existing Emergency Department Facility: Applicants seeking expansion of the existing host hospital ED through the establishment of a FSED in order to decompress patient volumes should demonstrate the existing ED of the host hospital is operating at capacity. This determination should be based upon the annual visits per treatment room at the host hospital's emergency department (ED) as identified by the American College of Emergency Physicians (ACEP) in Emergency Department Design: A Practical Guide to Planning for the Future, Second Edition as capacity for EDs. The capacity levels set forth by this document should be utilized as a guideline for describing the potential of a respective functional program. The applicant shall utilize the applicable data in the Hospital Joint Annual Report to demonstrate total annual ED volume and annual emergency room visits. The annual visits per treatment room should exceed what is outlined in the ACEP document. Because the capacity levels set forth in the**

Emergency Department Design: A Practical Guide to Planning for the Future, Second Edition are labeled in the document as a "preliminary sizing chart", the applicant is encouraged to provide additional evidence of the capacity, efficiencies, and demographics of patients served within the existing ED facility in order to better demonstrate the need for expansion. See Standard 1, Demonstration of Need, for examples of additional evidence.

Additionally, the applicant should discuss why expansion of the existing ED is not a viable option. This discussion should include any barriers to expansion including, but not limited to, economic efficiencies, disruption of services, workforce duplication, restrictive covenants, and issues related to access. The applicant should also provide evidence that all practical efforts to improve efficiencies within the existing ED have been made, including, but not limited to, the review of and modifications to staffing levels.

Applicants seeking to decompress volumes of the existing host hospital ED should be able to demonstrate need for the additional facility in the proposed service area as defined in the application in accordance with Standard 1, Determination of Need.

Response

*** Not applicable. ***

3. Relationship to Existing Similar Services in the Area: The proposal shall discuss what similar services are available in the service area and the trends in occupancy and utilization of those services. This discussion shall include the likely impact of the proposed FSED on existing EDs in the service area and shall include how the applicant's services may differ from existing services. Approval of the proposed FSED should be contingent upon the applicant's demonstration that existing services in the applicant's proposed geographical service area are not adequate and/or there are special circumstances that require additional services.

Rural: The applicant should provide patient origin data by ZIP Code for each existing facility as well as the proposed FSED in order to verify the proposed facility will not negatively impact the patient base of the existing rural providers. The establishment of a FSED in a rural area should only be approved if the applicant can adequately demonstrate the proposed facility will not negatively impact any existing rural facilities that draw patients from the proposed service area. Additionally, in an area designated as rural, the proposed facility should not be located within 10 miles of an existing facility. Finally, in rural proposed service areas, the location of the proposed FSED should not be closer to an existing ED facility than to the host hospital.

Critical Access Hospitals (CAH): In Tennessee, certain CAHs are not located in rural areas according to the definition of rural provided in these standards. The location of the proposed FSED should not be closer to an existing CAH than to the host hospital.

Response

There are no other providers of emergency department services in Bledsoe County, Tennessee, which is classified as medically underserved. *Erlanger Bledsoe Hospital* has also received designation as a "necessary provider" from both the State of Tennessee and CMS. As part of a critical access hospital, the emergency department at *Erlanger Bledsoe Hospital* and its provider based emergency department in Sequatchie County, meet all access and geographical standards as promulgated for critical access hospitals by CMS.

4. Host Hospital Emergency Department Quality of Care: Additionally, the applicant shall provide data to demonstrate the quality of care being provided at the ED of the host hospital. The quality metrics of the host hospital should be in the top quartile of the state in order to be approved for the establishment of a FSED. The applicant shall utilize the Joint Commission's hospital outpatient core measure set. These measures align with CMS reporting requirements and are available through the CMS Hospital Compare website. Full details of these measures can be found in the Joint Commission's Specification Manual for National Hospital Outpatient Department Quality

Measures.

OP-1 Median Time to Fibrinolysis
OP-2 Fibrinolytic Therapy Received Within 30 Minutes
OP-3 Median Time to Transfer to Another Facility for Acute Coronary Intervention
OP-4 Aspirin at Arrival
OP-5 Median Time to ECG
OP-18 Median Time from ED Arrival to Departure for Discharged ED Patients
OP-20 Door to Diagnostic Evaluation by a Qualified Medical Personnel
OP-21 ED-Median Time to Pain Management for Long Bone Fracture
OP-23 ED-Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients who Received Head CT or MRI Scan Interpretation With 45 Minutes of ED Arrival

Sources:

https://www.jointcommission.org/hospital outpatient department/
https://www.jointcommission.org/assets/1/6/HAP Outpatient Dept Core Measure Set.pdf
https://www.medicare.gov/hospitalcompare/search.html
https://data.medicare.gov/data/hospital-compare

Note: The above measures are found in the category "Timely and Effective Care".

Note: Health Planning recognizes that limitations may exist for specific metrics listed above. When significant limitations exist (e.g. there are not adequate volumes to evaluate) applicants may omit these metrics from the application. However, the application should then discuss the limitations and reasoning for omission. Applicants are encouraged to supplement the listed metrics with additional metrics that may provide HSDA with a more complete representation of the need for emergency care services in the proposed service area.

Response

Pertaining to the operating metrics identified within this criterion, data is not available for all indicators on the *Medicare Hospital Compare* website. However, data is available for a few of the indicators, as listed here:

Ind.	*Description*	*Value*

OP-4	Aspirin At Arrival	99 %
OP-18	Median Time From ED Arrival To Departure For Discharged ED Patients	95 min.
OP-20	Door To Diagnostic Eval	25 min.
OP-21	Median Time To Pain Med	49 min.
OP-22	Left Before Being Seen	2 %

A copy of the Medicare Hospital Compare data is attached to this CON application.

Erlanger Bledsoe Hospital compares favorably with both state and national averages. Metrics for the provider based emergency department in Sequatchie County are combined with those of *Erlanger Bledsoe Hospital* as provider based emergency as specified by CMS. *Erlanger Bledsoe Hospital* and its provider based ED are both accredited by *The Joint Commission*. *Erlanger Sequatchie Valley Regional Hospital* and its provider based emergency department will also be accredited by *The Joint Commission*.

5. Appropriate Model for Delivery of Care: The applicant should discuss why a FSED is the appropriate model for delivery of care in the proposed service area.

Response

Erlanger Bledsoe Hospital has demonstrated that its provider based emergency department in Sequatchie County was the right model for the needs of the community as evidenced by the improvements in health status that have been realized since the emergency department was opened. With the Sequatchie County EMS service and a helipad on-site, community residents have timely access to a full range of emergency medical services inclusive of Level I trauma services for adults and children, *Erlanger Medical Center - University Hospital*. As the only Level I trauma service provider, *Erlanger Medical Center - University Hospital* also provides medical supervisory oversight for the entire thirteen (13) county region to ensure access to timely medical care thru its regional operations center.

As a safety net provider with six (6) helicopters, *Erlanger Health System* provides essential services to those in need. *Erlanger Health System* is the 7th largest public health system in the United States. For the proposed project, it is anticipated that the community benefit in Bledsoe County will be at least equal to that realized with

the hospital, though likely greater given the improved facilities and accessible location. As integral providers of *Erlanger Health System*, the new hospital and its provider based emergency department will have access to highly specialized resources in emergency medicine, Level I trauma services for adult and children, a fleet of air ambulances and a graduate medical training program for Emergency physicians. *Erlanger's* reputation in emergency medicine is national in scope, with *Erlanger Medical Center – University Hospital* hosting national trauma meetings and associated educational and credentialing meetings. *Erlanger* is one of only a few hospitals in the country that have the ability to raise the standard of care in the delivery of emergency medicine.

6. **Geographic Location: The FSED should be located within a 35 mile radius of the hospital that is the main provider.**

Response

The provider based emergency department in Pikeville, Bledsoe County, will be located approximately twenty two (22) miles from *Erlanger Sequatchie Valley Regional Hospital*. Both of these sites meet CMS location standards and requirements for a critical access hospital.

7. **Access: The applicant must demonstrate an ability and willingness to serve equally all of the service area in which it seeks certification. In addition to the factors set forth in HSDA Rule 0720-11-.01(1) (listing factors concerning need on which an application may be evaluated), the HSDA may choose to give special consideration to an applicant that is able to show that there is limited access to ED services in the proposed Service Area.**

Response

Erlanger Health System is a safety net provider for Tennessee and has a demonstrated track record of serving all patients regardless of ability to pay. *Erlanger Health System* annually provides more uncompensated care than all other hospitals in the region combined, the annual cost of this care typically exceeds $100 million. *Erlanger Medical*

Center - University Hospital is where community hospitals send their most difficult cases. *Erlanger Health System* also operates a "system of care" that facilitates access to a broad range of tertiary services including Level I trauma services for adults and children.

8. **Services to High-Need Populations: Special consideration shall be given to applicants providing services fulfilling the unique needs and requirements of certain high-need populations, including patients who are uninsured, low income, or patients with limited access to emergency care.**

Response

Erlanger Health System is a safety net provider for Tennessee and has a demonstrated track record of serving all patients regardless of ability to pay. *Erlanger Health System* annually provides more uncompensated care than all other hospitals in the region combined, the annual cost of this care typically exceeds $100 million. *Erlanger Medical Center - University Hospital* is where community hospitals send their most difficult cases. *Erlanger Health System* also operates a "system of care" that facilitates access to a broad range of tertiary services including Level I trauma services for adults and children.

9. **Establishment of Non-Rural Service Area: The geographic service area shall be reasonable and based on an optimal balance between population density and service proximity of the applicant. The socio-demographics of the service area and the projected population to receive services shall be considered. The applicant shall demonstrate the orderly development of emergency services by providing information regarding current patient origin by ZIP Code for the hospital's existing ED in relation to the proposed service area for the FSED.**

Establishment of a Rural Service Area: Applicants seeking to establish a freestanding emergency department in a rural area with limited access to emergency medical care shall establish a service area based upon need. The applicant shall demonstrate the orderly development of emergency services by providing

information regarding patient origin by ZIP Code for the proposed service area for the FSED.

Response

Erlanger Bledsoe Hospital is the only provider of emergency department services in Bledsoe County, Tennessee. *Erlanger Bledsoe Hospital*, through it's emergency department locations, currently provides 65.6% of all such services for Bledsoe County; and Erlanger Health System combined provides 76.5% of all emergency department services for Bledsoe County. See table of ED patient destination below.

ED Patient Destination From Bledsoe County, Tennessee

[Bledsoe County = Zip Code 37367]

	CY		
	2014	2015	2016
Erlanger Bledsoe	4,109	4,212	4,322
Erlanger Med Cntr-Baroness Hosp	648	700	712
Erlanger Sequatchie Valley ED	174	373	359
Erlanger North Hosp	28	24	31
Erlanger East	22	14	18
Total - Erlanger Health System	4,981	5,323	5,442
Market Share	70.2%	76.1%	76.5%
CHI Memorial Hosp-Hixson	120	102	88
CHI Memorial Hosp-Chattanooga	78	75	65
Parkridge Med Cntr	64	49	22
Parkridge West Hosp	32	20	11
Parkridge East Hosp	22	15	21
Cumberland Med Cntr	873	559	631
Rhea Med Cntr	567	558	517
Cookeville Reg Med Cntr	108	94	95
Saint Thomas Highlands Hosp	102	75	76
Saint Thomas River Park Hosp	25	19	22
Other	128	109	124
Total - Bledsoe County	7,100	6,998	7,114

10. Relationship to Existing Applicable Plans; Underserved Area and Population: The proposal's relationship to underserved geographic areas and underserved

OP-20 Door to Diagnostic Evaluation by a Qualified Medical Personnel
OP-21 ED-Median Time to Pain Management for Long Bone Fracture
OP-23 ED-Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients who Received Head CT or MRI Scan Interpretation With 45 Minutes of ED Arrival

Sources:

https://www.jointcommission.org/hospital outpatient department/
https://www.jointcommission.org/assets/1/6/HAP Outpatient Dept Core Measure Set.pdf
https://www.medicare.gov/hospitalcompare/search.html
https://data.medicare.gov/data/hospital-compare

Note: The above measures are found in the category "Timely and Effective Care".

The HSDA should consider additional data provided by the applicant to support the need for the proposed FSED including, but not limited to, data relevant to patient acuity levels, age of patients, percentage of behavioral health patients, and existence of specialty modules. These data may provide the HSDA with additional information on the level of need for emergency services in the proposed service area. If providing additional data, applicants should utilize Hospital Discharge Data System data (HDDS) when applicable. The applicant may utilize other data sources to demonstrate the percentage of behavioral health patients but should explain why the alternative data source provides a more accurate indication of the percentage of behavioral health patients than the HDDS data.

See Standard 2, Expansion of Existing Emergency Department Facility, for more information on the establishment of a FSED for the purposes of decompressing volumes and reducing wait times at the host hospital's existing ED.

Note: Health Planning recognizes that limitations may exist for specific metrics listed above. When significant limitations exist (e.g. there are not

population groups shall be a significant consideration.

Response

Erlanger Bledsoe Hospital is the only provider of emergency department services in Bledsoe County, Tennessee. *Erlanger Sequatchie Valley Regional Hospital* will have a helipad that provides access, via *Erlanger* helicopter, to Level I trauma services for adults and children. *Erlanger Medical Center – University Hospital* also provides emergency service oversight for the entire regional service area and is affiliated with the University of Tennessee – College of Medicine, to train emergency physicians, including a fellowship in advanced emergency medicine. *Erlanger Health System* continuously demonstrates its commitment to the underserved. It's effort have had a direct impact in improving health status for rural underserved communities using independently collected metrics.

11. **Composition of Services: Laboratory and radiology services, including but not limited to XRAY and CT scanners, shall be available on-site during all hours of operation. The FSED should also have ready access to pharmacy services and respiratory services during all hours of operation.**

Response

As with existing ED services provided by *Erlanger Bledsoe Hospital* at both locations, the same services will be provided by *Erlanger Sequatchie Valley Regional Hospital* and it's provider based ED in Pikeville, Bledsoe County. Services will be inclusive of on-site X-Ray, CT, Laboratory and Respiratory Therapy. Also, emergency medical professionals will staff the ED twenty-four (24) hours per day.

12. **Pediatric Care: Applicants should demonstrate a commitment to maintaining at least a Primary Level of pediatric care at the FSED as defined by CHAPTER 1200-08-30 Standards for Pediatric Emergency Care Facilities including staffing levels, pediatric equipment, staff training, and pediatric services.**

Applicants should include information detailing the expertise, capabilities, and/or training of staff to stabilize or serve pediatric patients. Additionally, applicants shall demonstrate a referral relationship, including a plan for the rapid transport, to at least a general level pediatric emergency care facility to allow for a specialized higher level of care for pediatric patients when required.

Response

Children's Hospital @ Erlanger, located in Chattanooga, Tennessee, is a state designated regional pediatric center. Access via *LifeForce* helicopter can be accomplished in a matter of minutes from Pikeville, Bledsoe County. The EMS service for Bledsoe County will be located within ½ mile of the new emergency department. Staff from *Children's Hospital @ Erlanger* provide education and training on appropriate protocol and treatment of pediatric emergencies. Erlanger Sequatchie Valley Regional Hospital and it's provider based ED will each have a helipad to foster patient transfer as needed.

13. **Assurance of Resources: The applicant shall document that it will provide the resources necessary to properly support the applicable level of emergency services.**

Included in such documentation shall be a letter of support from the applicant's governing board of directors or Chief Financial Officer documenting the full commitment of the applicant to develop and maintain the facility resources, equipment, and staffing to provide the appropriate emergency services. The applicant shall also document the financial costs of maintaining these resources and its ability to sustain them to ensure quality treatment of patients in the ED continuum of care.

Response

A letter from the CFO for *Erlanger Health System* is attached to this CON application. The letter assures *Erlanger's* commitment to the provider based ED which will be part of *Erlanger Sequatchie Valley Regional Hospital*. This commitment will be to provide necessary resources,

operate and staff the provider based ED sufficiently as to ensure high quality care, both within and along the ED continuum. Currently, *Erlanger Bledsoe Hospital* staffs the provider based emergency department in Dunlap, Sequatchie County, with physicians; it is expected that this project will be similarly staffed.

14. Adequate Staffing: An applicant shall document a plan demonstrating the intent and ability to recruit, hire, train, assess competencies of, supervise, and retain the appropriate numbers of qualified personnel to provide the services described in the application and that such personnel are available in the proposed service area. Each applicant shall outline planned staffing patterns including the number and type of physicians and nurses. Each FSED is required to be staffed by at least one physician and at least one registered nurse at all times (24/7/365). Physicians staffing the FSED should be board certified or board eligible emergency physicians. If significant barriers exist that limit the applicant's ability to recruit a board certified or board eligible emergency physician, the applicant shall document these barriers for the HSDA to take into consideration. Applicants are encouraged to staff the FSED with registered nurses certified in emergency nursing care and/or advanced cardiac life support. The medical staff of the FSED shall be part of the hospital's single organized medical staff, governed by the same bylaws. The nursing staff of the FSED shall be part of the hospital's single organized nursing staff. The nursing services provided shall comply with the hospital's standards of care and written policies and procedures.

Adequate Staffing of a Rural FSED: An applicant shall document a plan demonstrating the intent and ability to recruit, hire, train, assess competencies of, supervise, and retain the appropriate numbers of qualified personnel to provide the services described in the application and that such personnel are available in the proposed service area. Each applicant shall outline planned staffing patterns including the number and type of physicians. FSEDs proposed to be located in rural areas are required to be staffed in accordance with the Code of Federal Regulations Title 42, Chapter IV, Subchapter G, Part 485, Subpart F -

Conditions of Participation: Critical Access Hospitals (CAHs). This standard requires a physician, nurse practitioner, clinical nurse specialist, or physician assistant be available at all times the CAH operates. The standard additionally requires a registered nurse, clinical nurse specialist, or licensed practical nurse to be on duty whenever the CAH has one or more inpatients. However, because FSEDs shall be in operation 24/7/365 and because they will not have inpatients, a registered nurse, clinical nurse specialist, or licensed practical nurse shall be on duty at all times (24/7/365). Additionally, due to the nature of the emergency services provided at an FSED and the hours of operation, a physician, nurse practitioner, clinical nurse specialist, or physician assistant shall be on site at all times.

Source:

http://www.ecfr.gov/cgi-bin/textidx?rgn=div6&node=42:5.0.1.1.4.4#se42.5.485_1631

Response

Erlanger Bledsoe Hospital and its provider based ED have continuously operated without interruption and has maintained full accreditation for its services by *The Joint Commission*. *Erlanger Sequatchie Valley Regional Hospital* does not anticipate difficulties in staffing the provider based ED. There will be essentially no change in ED services.

As a rural CAH, *Erlanger Sequatchie Valley Regional Hospital* will staff the provider based ED in Bledsoe County in compliance with the Code of Federal Regulations, Title 42, Chapter IV, Subchapter G, Part 485, Subpart F – Conditions of Participation: Critical Access Hospitals (CAHs). At all times of operation, a qualified and licensed medical professional will be on-site to render patient care … such medical professional will be either a physician, nurse practitioner, clinical nurse specialist, or physician assistant. Additionally, a registered nurse, clinical nurse specialist, or licensed practical nurse will also be on duty.

15. Medical Records: The medical records of the FSED shall be integrated into a unified retrieval system with the host hospital.

Response

Erlanger Health System is currently implementing a new EMR system which should be completed in November, 2017. This new EMR system is fully integrated and will serve as a unified retrieval system across all hospitals and ambulatory care sites, including *Erlanger Bledsoe Hospital* and it's provider based ED in Sequatchie County. Upon approval of this project, the same EMR system will be installed in *Erlanger Sequatchie Valley Regional Hospital* and it's provider based ED in Pikeville, Bledsoe County, a described in the companion CON application.

16. Stabilization and Transfer Availability for Emergent Cases: The applicant shall demonstrate the ability of the proposed FSED to perform stabilizing treatment within the FSED and demonstrate a plan for the rapid transport of patients from the FSED to the most appropriate facility with a higher level of emergency care for further treatment. The applicant is encouraged to include air ambulance transport and an on-site helipad in its plan for rapid transport. The stabilization and transfer of emergent cases must be in accordance with the Emergency Medical Treatment and Labor Act.

Response

Erlanger Health System prides itself on the "system of care" that it has developed across a four state area, which includes *LifeForce* air ambulance & helicopter transfer, co-located EMS partnerships, emergency medical oversight and supervision, and physician training in emergency medicine. The depth and breadth of emergency medical services are unmatched elsewhere, while being fully integrated across the healthcare delivery system and the entire four (4) state regional service area. Transfer agreements are in place for many community hospitals in the regional service area. Please see the list attached to this CON application.

The provider based ED in Pikeville, Bledsoe County, will have a helipad to accommodate *LifeForce* air ambulance and helicopter transfer. EMS services from Bledsoe County are located within ½ mile of the site for *Erlanger Sequatchie Valley Regional Hospital – Satellite Emergency Department*. As necessary, the stabilization and transfer of emergent cases will be in accordance with the *Emergency Medical Treatment & Labor Act*. *Erlanger's* established "system of care" serves to offset the longer EMS express times typically found in a rural market (see attached article).

17. Education and Signage: Applicants must demonstrate how the organization will educate communities and Emergency medical services (EMS) on the capabilities of the proposed FSED and the ability for the rapid transport of patients from the FSED 13 to the most appropriate hospital for further treatment. It should also inform the community that inpatient services are not provided at the facility and patients requiring inpatient care will be transported by EMS to a full service hospital. The name, signage, and other forms of communication of the FSED shall clearly indicate that it provides care for emergency and/or urgent medical conditions without the requirement of a scheduled appointment. The applicant is encouraged to demonstrate a plan for educating the community on appropriate use of emergency services contrasted with appropriate use of urgent or primary care.

Response

Erlanger Bledsoe Hospital and its provider based ED have worked extensively with communities to educate them on the provision of services. Signage and naming conventions for *Erlanger Sequatchie Valley Regional Hospital* and it's provider based ED, will meet all CMS standards and guidelines. In addition, "Erlanger Notes" are delivered live monthly via the County Commission to the community to insure community awareness of essential services. *Erlanger* attributes its success in delivering services to the community, in part, to its efforts to engage and educate the community. The health of the population has shown measurable improvement.

18. Community Linkage Plan: The applicant shall describe its participation, if any, in a community linkage plan, including its relationships with appropriate health and outpatient behavioral health care system, including mental health and substance use, providers/services, providers of psychiatric inpatient services, and working agreements with other related community services assuring continuity of care. The applicant is encouraged to include primary prevention initiatives in the community linkage plan that would address risk factors leading to the increased likelihood of ED usage. Rationale: The State Health Plan moved from a primary emphasis of health care to an emphasis on "health protection and promotion". The development of primary prevention initiatives for the community advances the mission of the State Health Plan.

Response

As indicated, *Erlanger Health System* has worked extensively to ensure there are no gaps in the provision of needed services. It's "system of care" is well known to provide access to a broad based continuum of services, while ensuring continuity via an integrated EMR system. As a safety net, *Erlanger Bledsoe Hospital* and it's provider based ED assure access to all patients, regardless of their ability to pay. This assurance will remain in place with *Erlanger Sequatchie Valley Regional Hospital* and it's provider based ED. *Erlanger Bledsoe Hospital* has worked extensively with communities to educate them on the provision of services. In addition, "Erlanger Notes" are delivered live monthly via the County Commission to the community to insure community awareness of essential services. *Erlanger* attributes its success in delivering services to the community, in part, to its efforts to engage and educate the community. The health of the population has shown measurable improvement.

19. Data Requirements: Applicants shall agree to provide the Department of Health and/or the HSDA with all reasonably requested information and statistical data related to the operation and provision of services and to report that data in the time and format requested. As a standard practice, existing data reporting streams will be relied upon and adapted over

time to collect all needed information.

Response

Erlanger Sequatchie Valley Regional Hospital and it's provider based ED, will provide all reasonably requested information and statistical data related to the operation and provision of services. Also, to report such data as requested.

20. **Quality Control and Monitoring: The applicant shall identify and document its existing or proposed plan for data reporting, quality improvement, and outcome and process monitoring system. The FSED shall be integrated into the host hospital's quality assessment and process improvement processes.**

Response

Erlanger Bledsoe Hospital and it's provider based ED are accredited by *The Joint Commission*. They also participate in quality reporting and monitoring, as evidenced by the quality information discussed previously and attached to this CON application. The quality reporting and monitoring will continue with *Erlanger Sequatchie Valley Regional Hospital* and it's provider based ED.

21. **Provider-Based Status: The applicant shall comply with regulations set forth by 42 CFR 413.65, Requirements for a determination that a facility or an organization has provider-based status, in order to obtain provider-based status. The applicant shall demonstrate eligibility to receive Medicare and Medicaid reimbursement, willingness to serve emergency uninsured patients, and plans to contract with commercial health insurers.**

Response

Erlanger Sequatchie Valley Regional Hospital and it's provider based ED, as described in the companion CON application, have already received approval from CMS. A copy of the letter is attached to this CON application.

Erlanger Sequatchie Valley Regional Hospital will serve uninsured emergency patients. In addition, all commercial payors which have a contractual agreement with *Erlanger Health System* will be able to access all of these services.

22. Licensure and Quality Considerations: Any applicant for this CON service category shall be in compliance with the appropriate rules of the TDH, the EMTALA, along with any other existing applicable federal guidance and regulation. The applicant shall also demonstrate its accreditation status with the Joint Commission or other applicable accrediting agency. The FSED shall be subject to the same accrediting standards as the licensed hospital with which it is associated.

Response

Erlanger Bledsoe Hospital and it's provider based ED are accredited by *The Joint Commission.*, and they are also in compliance with rules of TDH, EMTALA and other applicable Federal regulations. Such accreditation will be maintained by *Erlanger Sequatchie Valley Regional Hospital* and it's provider based ED, upon approval and implementation of this project. A copy of the letter from *The Joint Commission* is attached to this CON application.

[End Of Responses To Standards & Criteria For Freestanding Emergency Departments, 2016 Update To Tennessee State Health Plan]

GENERAL QUESTIONS CONCERNING NEED, ECONOMIC FEASIBILITY, APPLICABLE QUALITY STANDARDS & CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTHCARE

(I.) *NEED*

1. Provide a response to each criterion and standard in Certificate of Need Categories in the State Health Plan that are applicable to the proposed project. Criteria and standards can be obtained

from the Tennessee Health services & Development Agency, or found on the Agency's website at http://www.tn.gov/hsda/article/hsda-criteria-and-standards.

Response

Responses to the *CON Criteria & Standards* applicable to this project have been addressed.

- Construction, Renovation, Expansion, And Replacement Of Healthcare Institutions
- Freestanding Emergency Departments

2. Describe the relationship of this project to the applicant facility's long range development plans, if any, and how it relates to related previously approved projects of the applicant.

Response

Erlanger Health System currently holds a CON for *Erlanger East Hospital* to initiate a satellite radiation therapy service along with the relocation of a Linear Accelerator from *Erlanger Medical Center – University Hospital* (no. CN1412-048); a CON (No. CN1601-002) to transfer ten (10) medical/surgical beds from *Erlanger Medical Center – University Hospital* to *Erlanger East Hospital* and convert them to NICU beds, for initiation of a Level III NICU service. Further, a CON is outstanding for *Erlanger Behavioral Health, LLC*, for a new eighty eight (88) bed behavioral health hospital (no. CN1603-012), which is currently under construction.

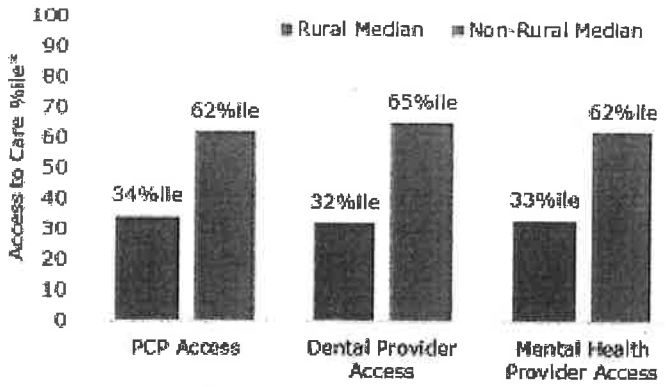
Erlanger Health System prides itself on the "system of care" that it has developed across a four state area, which includes *LifeForce* air ambulance & helicopter transfer, co-located EMS partnerships, emergency medical oversight and supervision, and physician training in emergency medicine. The depth and breadth of emergency medical services are unmatched elsewhere, while being fully integrated across the healthcare delivery system and the entire four (4) state regional service area. Transfer agreements are in place for many community hospitals in the regional service area. Please see the list attached to this CON application.

For overall rank pertaining to health outcomes, out of ninety-five (95) counties in Tennessee, Bledsoe County ranked number twenty (20) in 2013, and ranked seventeen (17) in 2017.

It should be noted that in 2013, *Erlanger Bledsoe Hospital* opened the first provider based emergency department in Tennessee which is part of a critical access hospital, in Dunlap, Sequatchie County, and we believe this ED, along with access to essential services, was instrumental to the improvement in health outcomes.

Further, the *Chartis Center For Rural Health* has illustrated the disparity of access to health services between rural and non-rural communities. (7)

Access to Healthcare in Rural Hospital Communities



***Population Health metrics are percentile ranked for all acute care rural and non-rural providers by hospital service area such that lower ranks indicate greater population challenges.**

Not surprisingly, access to care for rural areas is essentially equivalent to half of the availability for non-rural areas.

The goal for *Erlanger Health System* is to provide a comprehensive system of care comprised of unduplicated services while also serving those who are currently under served and/or those who do not have the ability to pay for their services. As such, *Erlanger Sequatchie Valley*

7 Chartis Center For Rural Health. *Rural Relevance for 2017: Assessing The State Of Rural Healthcare In America.* Retrieved from ... https://www.chartisforum.com/wp-content/uploads/2017/05/The-Rural-Relevance-Study_2017.pdf, p. 6.

Regional Hospital and it's provider based ED is part of a long term plan to make services more accessible.

3. **Identify the proposed service and justify the reasonableness of that proposed area. Submit a county level map for the Tennessee portion of the service area using the map on the following page, clearly marked to reflect the service area as it relates to meeting the requirements for CON criteria and standards that may apply to the project. Please include a discussion of the inclusion of counties in the border states, if applicable.**
Attachment – Section – Need – 3.

Please complete the following tables, if applicable:

Service Area Counties	*Historical Utilization - County Residents*	*% Of Total Procedures*
County 1		
County 2		
Etc.		
Total		

Response

The objective for *Erlanger Sequatchie Valley Regional Hospital – Satellite ED* is to foster access by creating a "regional system of care", of which the provider based ED is an essential component. By relocating the provider based ED to Bledsoe County, the population of the service area will have improved access.

Erlanger Bledsoe Hospital is the only provider of emergency department services in Bledsoe County, Tennessee. *Erlanger Bledsoe Hospital*, through it's emergency department locations, currently provides 65.6% of all such services for Bledsoe County; and *Erlanger Health System* combined provides 76.5% of all emergency department services for Bledsoe County. See table of ED patient destination below.

ED Patient Destination From Bledsoe County, Tennessee

[Bledsoe County = Zip Code 37367]

	CY		
	2014	2015	2016
Erlanger Bledsoe	4,109	4,212	4,322
Erlanger Med Cntr-Baroness Hosp	648	700	712
Erlanger Sequatchie Valley ED	174	373	359
Erlanger North Hosp	28	24	31
Erlanger East	22	14	18
Total - Erlanger Health System	4,981	5,323	5,442
Market Share	70.2%	76.1%	76.5%
CHI Memorial Hosp-Hixson	120	102	88
CHI Memorial Hosp-Chattanooga	78	75	65
Parkridge Med Cntr	64	49	22
Parkridge West Hosp	32	20	11
Parkridge East Hosp	22	15	21
Cumberland Med Cntr	873	559	631
Rhea Med Cntr	567	558	517
Cookeville Reg Med Cntr	108	94	95
Saint Thomas Highlands Hosp	102	75	76
Saint Thomas River Park Hosp	25	19	22
Other	128	109	124
Total - Bledsoe County	7,100	6,998	7,114

The service area is reasonable and provides balance between population density and service proximity. A map showing the service area is attached to this CON application.

4-A 1) Describe the demographics of the population to be served by the proposal.

Response

The objective for relocating the provider based ED from Sequatchie County is to foster access by assuring that emergency medical services continue to be available in Bledsoe County, Tennessee. Thus, patients will not need to travel to *Erlanger Sequatchie Valley Regional Hospital* in Dunlap, Tennessee, or elsewhere, for this needed health service.

Erlanger Bledsoe Hospital is the only provider of emergency department services in Bledsoe County, Tennessee. *Erlanger Bledsoe Hospital*, through it's emergency department locations, currently provides 65.6% of all such services for Bledsoe County; and *Erlanger Health System* combined provides 76.5% of all emergency department services for Bledsoe County. See table of ED patient destination below.

ED Patient Destination From Bledsoe County, Tennessee

[Bledsoe County = Zip Code 37367]

	CY		
	2014	**2015**	**2016**
Erlanger Bledsoe	4,109	4,212	4,322
Erlanger Med Cntr-Baroness Hosp	648	700	712
Erlanger Sequatchie Valley ED	174	373	359
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Cookeville Reg Med Cntr	108	94	95
Saint Thomas Highlands Hosp	102	75	76
Saint Thomas River Park Hosp	25	19	22
Other	128	109	124
Total - Bledsoe County	7,100	6,998	7,114

For the defined service area, the general population is expected to grow 1.4% compared to 4.2% for Tennessee. Those enrolled in TennCare comprise 22.9% of the population compared to 20.5% for Tennessee. Those living below the poverty level is 26.1% compared to 16.7% for Tennessee. Those over age 25 with less than a high school diploma is 27.1% compared to 15.2% for Tennessee. The median household income is $37,013 compared to $45,247

for Tennessee. The minority population is 7.38% compared to 24.58% for Tennessee. The elderly (age 65+) comprise 18.0% compared to 17.5% for Tennessee. For each of these measures, the service area is in a position strikingly opposite that of Tennessee.

2) **Using current and projected population data from the Department of Health, the most recent enrollee data from the Bureau of TennCare, and demographic information from the US Census Bureau, complete the following table and include data for each county in your proposed service area.**

Projected Population Data:
http://www.tn.gov/health/article/statistics-population
TennCare Enrollment Data:
http://www.tn.gov/tenncare/topic/enrollment-data
Census Bureau Fact Finder:
http://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml

	Dept. Of Health / Health Statistics						Bureau Of The Census				TennCare	
Demographic Variable / Geographic Area	Total Population - Current Year	Total Population - Projected Year	Total Population - % Change	(*) Target Population - Current Year	(*) Target Population - % Change	(*) Target Population - Projected Year As % Of Total	Median Age	Median Household Income	Persons Below Poverty Level	Persons Below Level As % Of Total	TennCare Enrollees	TennCare Enrollees As % Of Total
County A												
County B, etc.												
Service Area Total												
State Of TN Total												

(*) Target Population is population that project will primarily serve. For example, nursing home, home health agency, hospice agency projects typically primarily serve the Age 65+ population; projects for child & adolescent psychiatric services will serve the population ages 0-19. Projected Year is defined in select service-specific criteria and standards. If Projected Year is not defined, default should be four years from current year, e.g., if Current Year is 2016, then default Projected Year is 202.

Response

As requested, the table has been completed.

	Dept. Of Health / Health Statistics						Bureau Of The Census				TennCare	
Demographic Variable / Geographic Area	Total Population - Current Year	Total Population - Projected Year	Total Population - % Change	(*) Target Population - Current Year	(*) Target Population - % Change	(*) Target Population - Projected Year As % Of Total	Median Age	Median Household Income	Persons Below Poverty Level	Persons Below Level As % Of Total	TennCare Enrollees	TennCare Enrollees As % Of Total
Bledsoe County, Tennessee	13,333	13,516	1.4%	13,333	1.4%	100.0%	43.1	$37,013	3,480	26.1%	3,048	22.9%
Service Area Total	13,333	13,516	1.4%	13,333	2.4%	100.0%	42.6	$36,598	3,147	23.6%	3,048	22.9%
State Of TN Total	6,887,572	7,179,512	4.2%	6,887,572	4.2%	100.0%	38.7	$45,219	1,150,225	16.7%	1,412,063	20.5%

B. Describe the special needs of the service area population, including health disparities, the accessibility to consumers, particularly the elderly, women, racial and ethnic minorities, and low-income groups. Document how the business plans of the facility will take into consideration the special needs of the service area population.

Response

Erlanger Bledsoe Hospital is the only provider of emergency department services in Bledsoe County, Tennessee. *Erlanger Bledsoe Hospital*, through it's emergency department locations, currently provides 65.6% of all such services for Bledsoe County; and *Erlanger Health System* combined provides 76.5% of all emergency department services for Bledsoe County. See table of ED patient destination below.

ED Patient Destination From Bledsoe County, Tennessee

[Bledsoe County = Zip Code 37367]

	CY		
	2014	2015	2016
Erlanger Bledsoe	4,109	4,212	4,322
Erlanger Med Cntr-Baroness Hosp	648	700	712
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Total - Erlanger Health System	4,981	5,323	5,442
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Parkridge East Hosp	22	15	21
Cumberland Med Cntr	873	559	631
Rhea Med Cntr	567	558	517
Cookeville Reg Med Cntr	108	94	95
Saint Thomas Highlands Hosp	102	75	76
Saint Thomas River Park Hosp	25	19	22
Other	128	109	124
Total - Bledsoe County	7,100	6,998	7,114

For the defined service area, the general population is expected to grow 1.4% compared to 4.2% for Tennessee. Those enrolled in TennCare comprise 22.9% of the population compared to 20.5% for Tennessee. Those living below the poverty level is 26.1% compared to 16.7% for Tennessee. Those over age 25 with less than a high school diploma is 27.1% compared to 15.2% for Tennessee. The median household income is $37,013 compared to $45,247 for Tennessee. The minority population is 7.38% compared to 24.58% for Tennessee. The elderly (age 65+) comprise 18.0% compared to 17.5% for Tennessee. For each of these measures, the service area is in a position strikingly opposite that of Tennessee.

5. Describe the existing and approved but unimplemented CON's of similar healthcare providers in the service area. Include utilization and/or occupancy trends for

each of the most recent three years of data available for this project. List each provider and its utilization and/or occupancy individually. Inpatient bed projects must include the following data: Admissions or discharges, patient days, average length of stay, and occupancy. Other projects should use the most appropriate measures, e.g., cases, procedures, visits, admissions, etc. This doesn't apply to projects that are solely relocating a service.

Response

There are not currently any outstanding CON projects in the service area.

Erlanger Bledsoe Hospital is the only provider of emergency department services in Bledsoe County, Tennessee. *Erlanger Bledsoe Hospital*, through it's emergency department locations, currently provides 65.6% of all such services for Bledsoe County; and *Erlanger Health System* combined provides 76.5% of all emergency department services for Bledsoe County. See table of ED patient destination below, for the ED utilization of Bledsoe County.

ED Patient Destination From Bledsoe County, Tennessee

[Bledsoe County = Zip Code 37367]

	CY 2014	CY 2015	CY 2016	% Change 2014-2016
Erlanger Bledsoe	4,109	4,212	4,322	5.2%
Erlanger Med Cntr-Baroness Hosp	648	700	712	9.9%
Erlanger Sequatchie Valley ED	174	373	359	106.3%
Erlanger North Hosp	28	24	31	10.7%
Erlanger East	22	14	18	-18.2%
Total - Erlanger Health System	4,981	5,323	5,442	9.3%
Market Share	70.2%	76.1%	76.5%	9.0%
CHI Memorial Hosp-Hixson	120	102	88	-26.7%
CHI Memorial Hosp-Chattanooga	78	75	65	-16.7%
Parkridge Med Cntr	64	49	22	-65.6%
Parkridge West Hosp	32	20	11	-65.6%
Parkridge East Hosp	22	15	21	-4.5%
Cumberland Med Cntr	873	559	631	-27.7%
Rhea Med Cntr	567	558	517	-8.8%
Cookeville Reg Med Cntr	108	94	95	-12.0%
Saint Thomas Highlands Hosp	102	75	76	-25.5%
Saint Thomas River Park Hosp	25	19	22	-12.0%
Other	128	109	124	-3.1%
Total - Bledsoe County	7,100	6,998	7,114	0.2%

6. Provide applicable utilization and/or occupancy statistics for your institution for each of the past three (3) years and the projected annual utilization for each of the two (2) years following completion of the project. Additionally, provide the details regarding the methodology used to project utilization. The methodology must include detailed calculations or documentation from referral sources, and identification of all assumptions.

Response

The historical ED utilization for *Erlanger Bledsoe Hospital* is as follows, along with the projected ED utilization for the new provider based ED in Pikeville, Bledsoe County, Tennessee.

		=== Emergency Visits ====	
		Pikeville ED	Dunlap ED
Historical ED Utilization			
	2014	6,105	3,842
	2015	5,341	9,581
	2016	5,546	10,229
Projected ED Utilization			
	Year 1	5,600	11,000
	Year 2	5,678	11,220

(II.) *ECONOMIC FEASIBILITY*

1. Provide the cost of the project by completing the Project Costs Chart on the following page. Justify the cost of the project.

   A. All projects should have a project cost of at least $ 15,000 (the minimum CON filing fee). (See application instructions for filing fee.)

   B. The cost of any lease (building, land and/or equipment) should be based on fair market value or the total amount of the lease payments over the initial term of the lease, whichever is greater. Note: This applies to all equipment leases including by procedure or "per click" arrangements. The methodology used to determine the total lease cost for a "per click" arrangement must include, at a minimum, the projected procedures, the "per click" rate and the term of the lease.

   C. The cost for fixed and moveable equipment includes, but is not necessarily limited to, maintenance agreements covering the expected useful life of the equipment; federal, state and local taxes and other government assessments; and installation charges, excluding capital expenditures for physical plant renovation or in-wall shielding, which should be included under construction costs or incorporated in a facility lease.

D. Complete the Square Footage Chart on page 8 and provide the documentation. Please note the Total Construction Cost reported on line 5 of the Project Cost Chart should equal the Total construction Cost on the Square Footage Chart.

E. For projects that include new construction, modification, and/or renovation; documentation must be provided from a contractor and/or architect that support the estimated construction costs. Provide a letter that includes the following:

1.) A general description of the project;
2.) An estimate of the cost to construct the project;
3.) A description of the status of the site's suitability for the proposed project; and
4.) Attesting the physical environment will conform to applicable federal standards, Guidelines For Design & construction Of Hospital And Health Care Facilities in current use by the licensing authority.

Response

The *Project Cost Chart* has been completed on the next page, and the architect letter is attached to this CON application.

PROJECT COST CHART

A.	Construction And Equipment Acquired By Purchase.		
	1.	Architecural And Engineering Fees	145,464
	2.	Legal, Administrative, Consultant Fees (Excluding CON Filing Fees)	50,000
	3.	Acquisition Of Site	45,000
	4.	Preparation Of Site	200,000
	5.	Total Construction Cost	2,453,400
	6.	Contingency Fund	204,000
	7.	Fixed Equipment (Not Included In Construction Contract)	736,767
	8.	Moveable Equipment (List all equipment over $ 50,000 as separate attachments)	418,233
	9.	Other (Specify) Signage, IT, etc.	110,530
B.	Acquisition By Gift, Donation, Or Lease.		
	1.	Facility (inclusive of building and land)	0
	2.	Building Only	0
	3.	Land Only	0
	4.	Equipment (Specify) _____	0
	5.	Other (Specify) _____	0
C.	Financing Costs And Fees.		
	1.	Interim Financing	0
	2.	Underwriting Costs	0
	3.	Reserve For One Year's Debt Service	0
	4.	Other (Specify) _____	0
D.	Estimated Project Cost	(A + B + C)	4,363,394
E.	CON Filing Fee		25,090
F.	Total Estimated Project Cost	(D + E) **TOTAL**	4,388,484

2. Identify the funding sources for this project.

a. Please check the applicable item(s) below and briefly summarize how the project will be financed. (Documentation for the type of funding MUST be inserted at the end of the application, in the correct alpha/numeric order and identified as Attachment C, Economic Feasibility-2.)

___ A. Commercial Loan -- Letter from lending institution or guarantor stating favorable initial contact, proposed loan amount, expected interest rates, anticipated term of the loan, and any restrictions or conditions.

___ B. Tax - Exempt Bonds -- Copy of preliminary resolution or a letter from the issuing authority stating favorable initial contact and a conditional agreement from an underwriter or investment banker to proceed with the issuance.

___ C. General obligation bonds -- Copy of resolution from issuing authority or minutes from the appropriate meeting.

___ D. Grants -- Notification of intent form for grant application or notice of grant award.

___ E. Cash Reserves - Appropriate documentation from Chief Financial Officer of the organization providing the funding for the project and audited financial statements of the organization; and/or

_X_ F. Other - Identify and document funding from all other sources.

Response

Erlanger Sequatchie Valley Regional Hospital - Satellite ED in Pikeville, Tennessee, will be financed by Bledsoe County, Tennessee.

3. **Complete Historical Data Charts on the following two pages – *Do not modify the charts provided or submit Chart substitutions*!**

Historical Data Chart represents revenue and expense information for the last three (3) years for which complete data is available. Provide a Chart for the total facility and Chart just for the services being represented in the proposed project, if applicable. Only complete on chart if it suffices.

Note that "Management Fees to Affiliates" should include management fees paid by agreement to the parent company, another subsidiary of the parent company, or a third party with common ownership as the applicant entity. "Management Fees to Non-Affiliate" should include any management fees paid by agreement to third party entities not having common ownership with the applicant.

Response

The *Historical Data Charts for Erlanger Bledsoe Hospital* and *Erlanger Bledsoe Hospital – Satellite ED* have been completed.

[X] Total Facility
[ ] Project Only

HISTORICAL DATA CHART

Give information for the last *three (3)* years for which complete data are available for the facility or agency. The fiscal year begins in July (Month).

		Year – 2014	Year – 2015	Year – 2016
A.	Utilization Data (Specify Unit Of Measure, e.g., 1,000 patient days, 500 visits) *Admissions*	296	409	344
B.	Revenue From Services To Patients			
1.	Inpatient Services	2,987,745	3,808,307	4,624,277
2.	Outpatient Services	13,491,463	18,308,976	15,919,874
3.	Emergency Services	6,575,324	17,545,948	27,779,684
4.	Other Operating Revenue (Specify) Cafeteria, POB Rent, etc.	556,272	493,437	553,936
	Gross Operating Revenue	23,610,804	40,156,668	48,877,771
C.	Deductions From Gross Operating Revenue			
1.	Contractual Adjustments	11,254,224	22,510,486	29,757,443
2.	Provision For Charity Care	1,499,303	2,396,456	2,557,237
3.	Provision For Bad Debt	1,514,369	2,687,029	3,146,065
	Total Deductions	14,267,896	27,593,971	35,460,745
	NET OPERATING REVENUE	9,342,908	12,562,697	13,417,026
D.	Operating Expenses			
1.	Salaries And Wages			
	a. Direct Patient Care	3,082,935	4,672,107	4,350,575
	b. Non-Patient Care	1,193,574	1,808,830	1,684,347
2.	Physician's Salaries And Wages			
3.	Supplies	437,579	679,720	737,275
4.	Rent			
	a. Paid To Affiliates			
	b. To Non-Affiliates	200,117	200,117	204,357
5.	Management Fees			
	a. Paid To Affiliates			
	b. To Non-Affiliates			
6.	Other Operating Exp. (Specify) Insurance, Purch. Svcs., etc.	3,677,760	4,543,188	4,924,723
	Total Operating Expenses	8,591,965	11,903,962	11,901,277
E.	**Earnings Before Interest, Taxes & Depr.**	750,943	658,735	1,515,749
F.	Non-Operating Expenses			
1.	Taxes	5,495	5,225	11,066
2.	Depreciation	142,626	163,585	174,263
3.	Interest			
4.	Other Non-Operating Expenses			
	Total Non-Oper. Exp.	148,121	168,810	185,329
	NET INCOME (LOSS)	602,822	489,925	1,330,420

G. Other Deductions			
1. Annual Principal Debt Repayment			
2. Annual Capital Expenditure			
Total Other Deductions			
NET BALANCE	602,822	489,925	1,330,420
DEPRECIATION	142,626	163,585	174,263
FREE CASH FLOW (Net Balance + Depreciation)	745,448	653,510	1,504,683

☑ Total Facility
☐ Project Only

HISTORICAL DATA CHART -- OTHER EXPENSES

Other Expense Categories		Year - 2014	Year – 2015	Year – 2016
1.)	Purchased Services	2,105,584	2,939,895	3,335,312
2.)	Utilities	189,480	227,272	286,483
3.)	Drugs	230,596	224,405	223,607
4.)	Insurance	9,859	9,375	19,848
5.)	Corporate O/H Allocation	1,142,241	1,142,241	1,059,473
6.)				
7.)				
	Total -- Other Expenses	3,677,760	4,543,188	4,924,723

SUPPLEMENTAL #1
September 22, 2017
10:08 am

[ ] Total Facility
[X] Project Only

HISTORICAL DATA CHART

Give information for the last *three (3)* years for which complete data are available for the facility or agency. The fiscal year begins in July (Month).

		Year – 2014	Year – 2015	Year – 2016
A.	Utilization Data (Specify Unit Of Measure, e.g., 1,000 patient days, 500 visits) *ED Visits*	3,842	9,581	10,229
B.	Revenue From Services To Patients			
	1. Inpatient Services			
	2. Outpatient Services			
	3. Emergency Services	4,470,184	11,928,480	22,020,988
	4. Other Operating Revenue (Specify)			
	Gross Operating Revenue	4,470,184	11,928,480	22,020,988
C.	Deductions From Gross Operating Revenue			
	1. Contractual Adjustments	2,130,739	6,686,707	13,406,673
	2. Provision For Charity Care	283,860	711,864	1,152,116
	3. Provision For Bad Debt	286,712	798,178	1,417,402
	Total Deductions	2,701,311	8,196,749	15,976,191
	NET OPERATING REVENUE	1,768,873	3,731,731	6,044,797
D.	Operating Expenses			
	1. Salaries And Wages			
	a. Direct Patient Care	583,685	1,488,769	2,103,856
	b. Non-Patient Care	225,977	576,384	814,518
	2. Physician's Salaries And Wages			
	3. Supplies	82,846	201,910	432,166
	4. Rent			
	a. Paid To Affiliates			
	b. To Non-Affiliates	142,403	142,403	142,403
	5. Management Fees			
	a. Paid To Affiliates			
	b. To Non-Affiliates			
	6. Other Operating Exp.	696,303	1,349,547	2,528,744
	Total Operating Expenses	1,731,214	3,759,013	6,021,687
E.	**Earnings Before Interest, Taxes & Depr.**	37,659	(27,282)	23,110
F.	Non-Operating Expenses			
	1. Taxes	1,040	1,040	1,040
	2. Depreciation	27,003	27,003	27,003
	3. Interest			
	4. Other Non-Operating Expenses			
	Total Non-Oper. Exp.	28,043	28,043	28,043

SUPPLEMENTAL #1
September 22, 2017
10:08 am

NET INCOME (LOSS)	9,616	(55,325)	(4,933)
G. Other Deductions			
1. Annual Principal Debt Repayment			
2. Annual Capital Expenditure			
Total Other Deductions			
NET BALANCE	9,616	(55,325)	(4,933)
DEPRECIATION	27,003	27,003	27,003
FREE CASH FLOW (Net Balance + Depreciation)	36,619	(28,322)	22,070

☐ Total Facility
☑ Project Only

HISTORICAL DATA CHART -- OTHER EXPENSES

Other Expense Categories

		Year – 2014	Year – 2015	Year – 2016
1.)	Purchased Services	398,646	873,291	1,712,614
2.)	Utilities	35,874	67,511	147,103
3.)	Drugs	43,658	66,659	114,818
4.)	Insurance	1,867	2,785	10,192
5.)	Corporate O/H Allocation	216,258	339,301	544,017
6.)				
7.)				
	Total -- Other Expenses	696,303	1,349,547	2,528,744

4. Complete Projected Data Charts on the following two pages – ***Do not modify the charts provided or submit Chart substitutions***!

The Projected Data Chart requests information for the two years following the completion of the proposed services that apply to the project. Please complete two Projected Data Charts. One Projected Data Chart should reflect revenue and expense information for the ***Proposal Only*** (i.e., if the application is for additional beds, include anticipated revenue from the proposed beds only, not from all beds in the facility). The second Chart should reflect information for the total facility. Only complete one chart if it suffices.

Note that "Management Fees to Affiliates" should include management fees paid by agreement to the parent company, another subsidiary of the parent company, or a third party with common ownership as the applicant entity. "Management Fees to Non-Affiliate" should include any management fees paid by agreement to third party entities not having common ownership with the applicant.

Response

The *Projected Data Charts* for *Erlanger Sequatchie Valley Regional Hospital* and *Erlanger Sequatchie Valley Regional Hospital – Satellite ED* have been completed.

[X] Total Facility
[ ] Project Only

PROJECTED DATA CHART

Give information for the two years following the completion of this proposal. The fiscal year begins in July (Month).

		Year – 1	Year – 2
A.	Utilization Data (Specify Unit Of Measure, e.g., 1,000 patient days, 500 visits) *I/P Admissions*	842	859
B.	Revenue From Services To Patients		
1.	Inpatient Services	9,908,361	10,581,535
2.	Outpatient Services	15,907,398	17,329,219
3.	Emergency Services	36,450,179	39,055,348
4.	Other Operating Revenue (Specify) Cafeteria, POB Rent, etc.	506,981	522,190
	Gross Operating Revenue	62,772,919	67,488,292
C.	Deductions From Gross Operating Revenue		
1.	Contractual Adjustments	37,384,542	40,720,496
2.	Provision For Charity Care	3,087,411	3,362,912
3.	Provision For Bad Debt	3,798,317	4,137,254
	Total Deductions	44,270,270	48,220,662
	NET OPERATING REVENUE	18,502,649	19,267,630
D.	Operating Expenses		
1.	Salaries And Wages		
	a. Direct Patient Care	5,004,558	5,276,732
	b. Non-Patient Care	1,809,266	1,903,226
2.	Physician's Salaries And Wages	562,500	586,688
3.	Supplies	1,106,557	1,176,516
4.	Rent		
	a. Paid To Affiliates		
	b. To Non-Affiliates	2,301,268	2,301,268
5.	Management Fees		
	a. Paid To Affiliates		
	b. To Non-Affiliates		
6.	Other Operating Exp.	6,415,985	6,642,743
	Total Operating Expenses	17,200,134	17,887,173
E.	**Earnings Before Interest, Taxes & Depr.**	1,302,515	1,380,457
F.	Non-Operating Expenses		
1.	Taxes	5,500	5,500
2.	Depreciation		
3.	Interest		
4.	Other Non-Operating Expenses		
	Total Non-Oper. Exp.	5,500	5,500
	NET INCOME (LOSS)	1,297,015	1,374,957

G. Other Deductions		
1. Annual Principal Debt Repayment		
2. Annual Capital Expenditure		
Total Other Deductions		
NET BALANCE	1,297,015	1,374,957
DEPRECIATION		
FREE CASH FLOW (Net Balance + Depreciation)	1,297,015	1,374,957

☑ Total Facility
☐ Project Only

PROJECTED DATA CHART -- OTHER EXPENSES

Other Expense Categories

		Year - 1	Year - 2
1.)	Purchased Services	2,400,258	2,485,467
2.)	Utilities	232,189	245,540
3.)	Drugs	288,719	298,923
4.)	Insurance	5,976	6,284
5.)	Other	627,830	631,235
6.)	Corporate O/H Allocation	2,861,013	2,975,294
7.)			
	Total -- Other Expenses	6,415,985	6,642,743

[ ] Total Facility
[X] Project Only

PROJECTED DATA CHART

Give information for the two years following the completion of this proposal. The fiscal year begins in July (Month).

		Year – 1	Year – 2
A.	Utilization Data (Specify Unit Of Measure, e.g., 1,000 patient days, 500 visits) *ED Visits*	5,600	5,678
B.	Revenue From Services To Patients		
	1. Inpatient Services		
	2. Outpatient Services	6,627,925	7,078,226
	3. Emergency Services	12,296,446	13,260,610
	4. Other Operating Revenue (Specify) Non-Patient Svcs.	168,994	174,063
	Gross Operating Revenue	19,093,365	20,512,899
C.	Deductions From Gross Operating Revenue		
	1. Contractual Adjustments	12,144,747	13,197,286
	2. Provision For Charity Care	1,002,977	1,089,901
	3. Provision For Bad Debt	1,233,922	1,340,861
	Total Deductions	14,381,646	15,628,048
	NET OPERATING REVENUE	4,711,719	4,884,851
D.	Operating Expenses		
	1. Salaries And Wages		
	a. Direct Patient Care	1,594,912	1,655,557
	b. Non-Patient Care	857,612	892,533
	2. Physician's Salaries And Wages		
	3. Supplies	220,296	232,669
	4. Rent		
	a. Paid To Affiliates		
	b. To Non-Affiliates	521,446	521,446
	5. Management Fees		
	a. Paid To Affiliates		
	b. To Non-Affiliates		
	6. Other Operating Exp.	1,534,562	1,585,653
	Total Operating Expenses	4,728,828	4,887,858
E.	**Earnings Before Interest, Taxes & Depr.**	(17,109)	(3,007)
F.	Non-Operating Expenses		
	1. Taxes	1,100	1,100
	2. Depreciation		
	3. Interest		
	4. Other Non-Operating Expenses	1,100	1,100
	Total Non-Oper. Exp.		
	NET INCOME (LOSS)	(18,209)	(4,107)

G. Other Deductions		
1. Annual Principal Debt Repayment		
2. Annual Capital Expenditure		
Total Other Deductions		
NET BALANCE	(18,209)	(4,407)
DEPRECIATION		
FREE CASH FLOW (Net Balance + Depreciation)	(18,209)	(4,107)

☐ Total Facility
☑ Project Only

PROJECTED DATA CHART -- OTHER EXPENSES

Other Expense Categories

		Year - 1	Year - 2
1.)	Purchased Services	461,817	478,211
2.)	Utilities	80,759	85,403
3.)	Drugs	69,055	71,354
4.)	Insurance	1,657	1,717
5.)	Other	134,697	135,938
6.)	Corporate O/H Allocation	786,577	813,030
7.)			
	Total -- Other Expenses	1,534,562	1,585,653

5. **A. Please identify the project's average gross charge, average deduction from operating revenue, and average net charge using information from the Projected Data Chart for Year 1 and Year 2 of the proposed project. Please complete the following table.**

	Previous Year	*Current Year*	*Year 1*	*Year 2*	*% Change -- Current Year To Year 2*
Gross Charge (Gross Operating Revenue / Utilization Data)					
Deduction From Revenue (Total Deductions / Utilization Data)					
Average Net Charge (Net Oper. Revenue / Utilization Data)					

Response

For ED visits, the table has been completed.

	Previous Year	*Current Year*	*Year 1*	*Year 2*	*% Change -- Current Year To Year 2*
Gross Charge (Gross Operating Revenue / Utilization Data)	$1,245	$2,153	$3,410	$3,613	190.2%
Deduction From Revenue (Total Deductions / Utilization Data)	$856	$1,562	$2,568	$2,752	221.5%
Average Net Charge (Net Oper. Revenue / Utilization Data)	$389	$591	$841	$860	121.1%

B. Provide the proposed charges for the project and discuss any adjustment to current charges that will result from the implementation of the proposal. Additionally, describe the anticipated revenue from the project and the impact on existing patient charges.

Response

Please see the list of average patient charges below, by service line for *Erlanger Bledsoe Hospital - ED.* Applicant does revise it's patient charge structure on a periodic basis (i.e.-annually) during the budget cycle each fiscal year. However, applicant does not anticipate any changes to existing patient charges specifically as a result of this project.

	==== ED Visits - Bledsoe Cty ====			== Erlanger Bledsoe ED ==	
	Bledsoe Cty	EBH	Mkt Share	Total Visits	Avg. Charge
Blood and blood-forming organ dzs	18	5	27.8%	7	$2,515
Circulatory system dzs	701	350	49.9%	453	$3,652
Complic. pregnancy, childbirth, puerperium	70	12	17.1%	17	$1,530
Condit originating in the perinatal period	5	2	40.0%	3	$3,391
Congenital anomalies	1		0.0%		
Digestive system dzs	589	324	55.0%	423	$2,703
Endo/nutrit/metab dzs and immune disorder	128	67	52.3%	104	$3,197
Genitourinary system dzs	399	200	50.1%	255	$3,135
Infectious and parasitic dzs	141	45	31.9%	59	$2,407
Injury and poisoning	1,429	909	63.6%	1,199	$1,918
Mental disorders	150	91	60.7%	117	$2,120
Musculoskel sys and connect tiss dzs	527	349	66.2%	442	$1,807
Neoplasms	23	9	39.1%	10	$2,250
Nerv system and sense organ dzs	607	407	67.1%	495	$1,914
Other conditions	960	639	66.6%	804	$3,132
Respiratory system dzs	1,038	684	65.9%	842	$2,260
Skin and subcutaneous tissue dzs	306	210	68.6%	261	$1,433
Unknown or No Diagnosis	22	19	86.4%	22	$1,365
Total	7,114	4,322	60.8%	5,513	$2,396

C. Compare the proposed charges to those of similar facilities in the service area/adjoining service areas, or to proposed charges of projects recently approved by the Health Services & Development Agency. If applicable, compare the proposed charges of the project to the current Medicare allowable fee schedule by common procedure terminology (CPT) codes(s).

Response

The average patient charge by outpatient service line for *Erlanger Bledsoe Hospital* and similar hospitals in Tennessee, for calendar year 2016, is below.

	== Erlanger Bledsoe ED ==		== Lauderdale Comm ED ==		== Camden General ED ==	
	Total Visits	Avg. Charge	Total Visits	Avg. Charge	Total Visits	Avg. Charge
Blood and blood-forming organ dzs	7	$2,515	112	$6,339	26	$3,163
Circulatory system dzs	453	$3,652	1,085	$5,091	747	$2,894
Complic. pregnancy, childbirth, puerperium	17	$1,530	98	$1,587	10	$1,595
Condit originating in the perinatal period	3	$3,391	6	$761	2	$1,485
Congenital anomalies			3	$1,555		
Digestive system dzs	423	$2,703	962	$3,670	755	$2,253
Endo/nutrit/metab dzs and immune disorder	104	$3,197	385	$5,126	182	$2,977
Genitourinary system dzs	255	$3,135	773	$4,728	452	$3,277
Infectious and parasitic dzs	59	$2,407	327	$2,308	93	$1,660
Injury and poisoning	1,199	$1,918	2,344	$2,060	1,689	$1,789
Mental disorders	117	$2,120	284	$3,500	206	$2,183
Musculoskel sys and connect tiss dzs	442	$1,807	589	$1,990	372	$1,280
Neoplasms	10	$2,250	28	$5,529	9	$2,754
Nerv system and sense organ dzs	495	$1,914	858	$2,026	456	$1,484
Other conditions	804	$3,132	767	$3,386	530	$2,576
Respiratory system dzs	842	$2,260	1,448	$3,272	692	$2,148
Skin and subcutaneous tissue dzs	261	$1,433	425	$1,983	231	$1,524
Unknown or No Diagnosis	22	$1,365	3	$2,499	17	$2,058
Total	5,513	$2,396	10,497	$3,189	6,469	$2,182

6. A. Discuss how projected utilization rates will be sufficient to support the financial performance. Indicate when the project's financial breakeven is expected and demonstrate the availability of sufficient cash flow until viability is achieved. Provide copies of the balance sheet and income statement from the most recent reporting period of the institution and the most recent audited financial statements with accompanying notes, if applicable. For all projects, provide financial information for the corporation, partnership, or principal parties that will be a source of funding for the project. Copies must be inserted at the end of the application, in the correct alpha numeric order and labeled as Attachment C, Economic Feasibility. Note: Publicly held entities only need to reference their SEC filings.

Response

The proposed project will operate at breakeven, with the possibility of a slight negative margin beginning in year one. Please see the *Projected Data Chart*. However, it should be noted that the provider based ED and the replacement hospital, as described in the companion CON application, are configured as a single hospital entity as per CMS approval … in order to sustain the facility from a financial perspective, it must be part of a critical access hospital. The combined project shows a positive margin in year 1 and year 2.

Erlanger Sequatchie Valley Regional Hospital – Satellite ED in Pikeville, Tennessee, will be financed by Bledsoe County, Tennessee.

B. Net Operating Margin Ratio – Demostrates how much revenue is left over after all the variable or operating costs have been paid. The formula for this ratio is: (Earnings Before Interest, Taxes & Depreciation / Net operating Revenue).

Utilizing information from the Historical and Projected Data Charts please report the net operating margin ratio trends in the following table.

Year	*2nd Year Previous To Current Year*	*1st Year Previous To Current Year*	*Current Year*	*Projected Year 1*	*Projected Year 2*
Net Operating Margin Ratio					

Response

As requested, the table has been completed.

Year	*2nd Year Previous To Current Year*	*1st Year Previous To Current Year*	*Current Year*	*Projected Year 1*	*Projected Year 2*
Net Operating Margin Ratio	2.1%	-0.7%	0.4%	-0.4%	0.0%

C. Capitalization Ratio (Long Term debt to capitalization) – Measures the proportion of debt financiang in a business's permanent (Long-term) financing mix. This ratio best measures a business's true capital structure because it is not affected by short-term financing decisions. The formula for this ratio is: (Long-term debt / (Long-term debt/Total Equity (Net Assets)) x 100).

For the entity (applicant and/or parent company) that is funding the proposed project please provide the capitalization ratio using the most

recent available from the funding entity's audited balance sheet, if applicable. The Capitalization Ratio's are not expected from outside the company lenders that provide funding.

Response

Erlanger Health System does not maintain a separate balance sheet for *Erlanger Bledsoe Hospital*. As such, the asset listing is maintained on the corporate schedules of *Erlanger Health System*. For this reason, the capitalization ratios pertaining to this question represent the financial status of *Erlanger Health System*.

Based on the audited financial statements for *Erlanger Health System* at June 30, 2016 (copy attached), the capitalization ratio is 46.8, calculated as follows.

1.)	Long Term Debt	$208,007,048
2.)	Total Equity (Net Assets)	$235,907,342
3.)	Long Term Debt + Total Equity	$443,914,390
	Ratio (Line 1 / Line 3) x 100	46.86

7. Discuss the project's participation in state and federal revenue programs including a description of the extent to which Medicare, TennCare/Medicaid, and medically indigent patients will be served by the project. Additionally, report the estimated gross operating revenue dollar amount and percentage of projected gross operating revenue anticipated by payor classification for the first year of the project by completing the table below.

Applicant's Projected Payor Mix, Year 1

	Projected Gross Operating Revenue	*As A % Of Total*
Medicare / Medicaid Managed Care		
TennCare / Medicaid		
Commercial / Other Managed Care		
Self - Pay		
Charity Care		
Other (Specify _____)		
Total		

Response

As requested, the table has been completed below.

	Projected Gross Operating Revenue	*As A % Of Total*
Medicare / Medicaid Managed Care	5,097,928	26.7%
TennCare / Medicaid	6,644,491	34.8%
Commercial / Other Managed Care	4,677,874	24.5%
Self - Pay	1,699,309	8.9%
Charity Care	935,575	4.9%
Other (Specify _____)	38,188	0.2%
Total	19,093,365	100.0%

It should be noted that *Erlanger Health System* provides close to $ 100 million in uncompensated car per year.

8. Provide the projected staffing for the project in Year 1 and compare to the current staffing for the most recent 12-month period, as appropriate. This can be reported using full-time equivalent (FTE's) positions for these positions. Additionally, please identify projected salary amounts by position classifications and compare the clinical staff salaries to prevailing wage patterns in the proposed service area as published by the Department of Labor & Workforce Development and/or other documented sources

Position Classification	*Existing FTE's*	*Projected FTE's*	*Average Wage (Contractual Rate)*	*Area Wide / State Wide Average Wage*
A. Direct Patient Care Positions				
Position 1				
Position 2				
Etc.				
Total - Direct Patient Care Positions				
B. Non-Patient Care Positions				
Position 1				
Position 2				
Etc.				
Total - Non-Patient Care Positions				
Total Employees *(A + B)*				
C. Contractual Staff				
Total Staff *(A + B + C)*				

Response

As requested, the table has been completed.

Erlanger Sequatchie Valley Regional Hospital -- Satellite ED
Position Listing

	Existing FTE's	Projected FTE's	EHS Avg. Wage	Area Avg. Wage
Direct Patient Care Positions				
Nurse Practitioner (Non Exepmt)	3.0	3.0	53.88	46.70
Pharmacist, Staff	2.2	2.2	62.97	53.95
Rad Tech, Spec Proc	5.0	5.0	23.10	23.30
RN, Staff	9.2	9.2	29.89	27.50
Total - Direct Patient Care Positions	19.4	19.4		
Non-Direct patient Care Positions				
Med Technologist	5.0	5.0	33.02	22.86
Nurse Manager	2.4	2.4	45.36	41.83
Unit Clerk	11.2	11.2	13.25	12.37
Other / Miscellaneous	4.0	4.0	20.22	17.04
Total - Non Patient Care Positions	22.6	22.6		
Total Employees	42.0	42.0		
Contractual Staff	0.0	0.0		
Total Staff	42.0	42.0		

9. Describe all alternatives to this project which were considered and discuss the advantages and disadvantages of each alternative including but not limited to:

A. Discuss the availability of less costly, more effective and/or more efficient alternative methods of providing the benefits intended by the proposal. If development of such alternatives is not practicable, justify why not, including reasons as to why they were rejected.

B. Document that consideration has been given to alternatives to new construction, e.g., modernization or sharing arrangements.

Response

Renovation of *Erlanger Bledsoe Hospital* was considered. However, the age and condition of the physical plant are such that it is not practical to renovate, simply because it has outlived it's useful life as a hospital. For example, current standards for space requirements are significantly different than what was applicable in 1971. The facility is also located in a residential area and is not readily accessible.

(III.) *CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE*

1. List all health care providers (e.g., hospitals, nursing homes, home care organizations, etc.), managed care organizations, alliances, and/or networks with which the applicant currently has or plans to have contractual and/or working relationships, e.g., transfer agreements, contractual agreements for health services.

Response

The most significant relationship between this proposal and the existing healthcare system is that it will be part of an existing health system and enhance *Erlanger Health System's* ability to integrate its services within the regional service area as the safety net provider, trauma center and region's only academic medical center. A list of the patient transfer agreements, along with a list of the currently contracted payor organizations, is attached to this CON application.

By providing these services regardless of a patient's ability to pay, the regional healthcare delivery system is positively impacted by the services envisioned in the instant application.

The applicant will have transfer arrangements with the following hospitals which are owned by *Erlanger Health System*.

-- Erlanger Medical Center
-- Erlanger North Hospital
-- T. C. Thompson Children's Hospital
-- Erlanger Bledsoe Hospital

Further, Erlanger currently has patient transfer agreements in place with more than 70 hospitals and other providers in the four (4) state area. These providers refer patients to *Erlanger* because of the depth and breadth of its programs and services. A copy of the list of transfer agreements is attached to this CON application.

2. Describe the effects of competition and/or duplication of the proposal on the healthcare system, including the impact to consumers and existing providers in the service area. Discuss any instances of competition and/or duplication arising from your proposal including a description of the effect the proposal will have on the utilization rates of existing providers in the service area of the project.

A. Positive Effects

Response

The effects of this proposal will be positive for the healthcare system because it will deliver the most appropriate level of care for those who are in need of emergency medical service regardless of ability to pay, and thereby, will also serve to foster improved access to care. The regional healthcare delivery system is positively impacted by serving those who are otherwise in need of these necessary services, regardless of their ability to pay.

B. Negative Effects

Response

Applicant does not envision any negative effects of this proposal on the healthcare system. There are not any other providers in the service area, therefore, effects of competitive interest are not an issue.

3. A. Discuss the availability of and accessibility to human resources required by the proposal, including clinical leadership and adequate professional staff, as per the State Of Tennessee licensing requirements and/or requirements of accrediting agencies, such as the Joint Commission and Commission On Accreditation Of Rehabilitation Facilities.

Response

Staffing for the proposal is expected to be essentially the same as it is currently at *Erlanger Bledsoe Hospital*. All current staff will be offered their same position at *Erlanger Sequatchie Valley Regional Hospital – Satellite ED*.

Erlanger Bledsoe Hospital and it's provider based ED are accredited by *The Joint Commission*, and they are also in compliance with rules of the Tennessee Dept. of Health, and other applicable Federal regulations. Such accreditation will be maintained by *Erlanger Sequatchie Valley Regional Hospital* and it's provider based ED, as described in the companion CON application, upon approval and implementation of this project. A copy of the letter from *The Joint Commission* is attached to this CON application.

B. Verify that the applicant has reviewed and understands all licensing and/or certification as required by the State of Tennessee and/or accrediting agencies for medical/clinical staff. These include, without limitation, regulations concerning clinical leadership, physician supervision, quality assurance policies and programs, utilization review policies and programs,

record keeping, clinical staffing requirements, and staff education.

Response

The Applicant has reviewed and intends to comply with all licensing and certification requirements imposed by applicable statutes, regulations, and accreditation standards.

C. Discuss the applicant's participation in the training of students in the areas of medicine, nursing, social work, etc. (e.g.-internships, residencies, etc.).

Response

Erlanger Health System, as the region's only academic medical center, has established strong long term relationships with the region's colleges, universities and clinical programs. *Erlanger* provides clinical sites for internships and rotation programs in nursing, radiology, respiratory, pharmacy and surgery technology, to name a few. It is also expected that *Erlanger Behavioral Health* will do so as well.

A number of regional universities offer Bachelor degree programs in nursing and physical therapy. *Erlanger* works closely with the *University of Tennessee at Chattanooga* to assist nurses transitioning from RN to BSN. Erlanger provides a teaching environment for staff as well with various on-the-job training opportunities (ex: CT for Radiologic Technologist, Certification for LPNs). Locally, two year degrees are available in many clinical allied health areas with additional programs offering advanced technical training in Radiological Imaging such as Nuclear Medicine, Diagnostic Ultrasonography, etc. *Erlanger Health System* participates with numerous schools that provide advanced training in the areas of nursing and allied health.

Erlanger has established strong long term relationships with the region's colleges, universities and clinical programs. *Erlanger* provides clinical sites for internships and rotation programs in nursing, radiology, respiratory care and pharmacy, to name a few. A number of

regional universities offer Bachelor degree programs in nursing and physical therapy. Locally, two year degrees are available in many clinical allied health areas with additional programs offering advanced technical training in Radiological Imaging such as Nuclear Medicine and Diagnostic Ultrasonography.

The *University of Tennessee - College of Medicine* is co-located at *Erlanger* and includes training of senior medical students on clinical rotation as well as graduate medical education for training of residents and advanced fellowships in various medical specialties, including surgical specialties, as outlined below.

Residency Programs

- Emergency Medicine
- Family Medicine
- Internal Medicine
- Obstetrics & Gynecology
- Orthopedic Surgery
- Pediatrics
- Plastic Surgery
- Surgery
- Urology
- Transitional Year

Fellowship Programs

- Cardiovascular Disease
- Colon & Rectal Surgery
- Emergency Medicine
- Gastroenterology
- Gynecologic Surgery - Minimally Invasive
- Neuro-Interventional Surgery
- Orthopedic Trauma Surgery
- Surgical Critical Care
- Vascular Surgery
- Ultrasound
- Transitional Year

Erlanger Health System is also a member of the *Vanderbilt University Medical Center - Health Network*. This affiliation will further enhance our ability to provide state of the art research, education and training programs. *Erlanger Health System* has also affiliated with *Technion Institute Of Technology*, in Haifa, Israel, for training of medical students, as well as graduate medical education, residency training and research. Increased

opportunity exists in various medical specialties to potentially add to *Erlanger's* growing portfolio of medical research and training programs.

Erlanger Health System also participates with numerous schools that provide advanced training in the areas of nursing and allied health.

4. Identify the type of licensure and certification requirements applicable and verify the applicant has reviewed and understands them. Discuss any additional requirements, if applicable. Provide the name of the entity from which the applicant has received or will receive licensure, certification, and/or accreditation.

Licensure: State of Tennessee, Dept. of Health

Certification Type (e.g. Medicare SNF, Medicare LTAC, etc.):

** Not applicable to this project. **

Accreditation: Joint Commission on Accreditation of Healthcare Organizations

A. If an existing institution, please describe the Current standing with any licensing, certifying, or accrediting agency or commission. Provide a copy of the current license of the facility.

Response

Erlanger Bledsoe Hospital and it's provider based ED are accredited by *The Joint Commission*, and are also licensed by the Tennessee Dept. of Health and are in compliance with current rules. They are also in compliance with applicable Federal regulations. Such accreditation and licensure will be maintained by *Erlanger Sequatchie Valley Regional Hospital* and it's provider based ED, as described in the companion CON application, upon approval and implementation of this project. A copy of the letter from *The Joint Commission* and the license for Erlanger Bledsoe Hospital are attached to this CON application.

B. For existing providers, please provide a copy of the most recent statement of deficiencies/plan of correction and document that all deficiencies/findings have been corrected by providing a letter from the appropriate agency.

Response

As requested, a copy of the most recent *Statement Of Deficiencies & Plan Of Correction*, is attached to this CON application.

C. Document and explain inspections within the last three survey cycles which have resulted in any of the following state, federal, or accrediting body actions: suspension of admissions, civil monetary penalties, notice of 23-day or 90-day termination proceedings from Medicare/Medicaid/TennCare, revocation/denial of accreditation, or other similar actions.

Response

Erlanger Bledsoe Hospital, in the last three (3) survey cycles, has not had any results leading to suspension of admissions, civil monetary penalties, or notice of termination proceedings.

1.) Discuss what measures the applicant has or will put in place to avoid similar findings in the future.

Response

*** Not applicable. ****

5. Respond to all of the following and for such occurrences, identify, explain and provide documentation:

A. Has any of the following:

1.) Any person(s) or entity with more than 5% ownership (direct or indirect) in the applicant

B. For existing providers, please provide a copy of the most recent statement of deficiencies/plan of correction and document that all deficiencies/findings have been corrected by providing a letter from the appropriate agency.

Response

As requested, a copy of the most recent *Statement Of Deficiencies & Plan Of Correction*, is attached to this CON application.

C. Document and explain inspections within the last three survey cycles which have resulted in any of the following state, federal, or accrediting body actions: suspension of admissions, civil monetary penalties, notice of 23-day or 90-day termination proceedings from Medicare/Medicaid/TennCare, revocation/denial of accreditation, or other similar actions.

Response

Erlanger Bledsoe Hospital, in the last three (3) survey cycles, has not had any results leading to suspension of admissions, civil monetary penalties, or notice of termination proceedings.

1.) Discuss what measures the applicant has or will put in place to avoid similar findings in the future.

Response

*** Not applicable. ****

5. Respond to all of the following and for such occurrences, identify, explain and provide documentation:

A. Has any of the following:

1.) Any person(s) or entity with more than 5% ownership (direct or indirect) in the applicant

(to include any entity in the chain of ownership for applicant);

Response

Erlanger Bledsoe Hospital, and it's successor *Erlanger Sequatchie Valley Regional Hospital*, if approved, are currently and will be a member of *Erlanger Health System*, which is a governmental unit authorized by an act of the *Tennessee General Assembly* in formation of the *Chattanooga-Hamilton County Hospital Authority*. As a governmental unit, with "public ownership" by the people of the State of Tennessee, no person or entity owns more than 5%, either directly or indirectly.

2.) **Any entity in which any person(s) or entity with more than 5% ownership (direct or indirect) in the applicant (to include any entity in the chain of ownership for the applicant) has an ownership interest of more than 5%; and/or**

Response

Erlanger Bledsoe Hospital, and it's successor *Erlanger Sequatchie Valley Regional Hospital*, if approved, are currently and will be a member of *Erlanger Health System*, which is a governmental unit authorized by an act of the *Tennessee General Assembly* in formation of the *Chattanooga-Hamilton County Hospital Authority*. As a governmental unit, with "public ownership" by the people of the State of Tennessee, no person or entity owns more than 5%, either directly or indirectly.

3.) **Any physician or other provider of healthcare, or administrator employed by any entity in which any person(s) or entity with more than 5% ownership in the applicant (to include any entity in the chain of ownership for applicant) has an ownership interest of more than 5%.**

Response

Erlanger Bledsoe Hospital, and it's successor *Erlanger Sequatchie Valley Regional Hospital*, if approved,

are currently and will be a member of *Erlanger Health System*, which is a governmental unit authorized by an act of the *Tennessee General Assembly* in formation of the *Chattanooga-Hamilton County Hospital Authority*. As a governmental unit, with "public ownership" by the people of the State of Tennessee, no person or entity owns more than 5%, either directly or indirectly.

B. Been subjected to any of the following:

1.) Final Order or Judgment in a state licensure action;

Response

Erlanger Bledsoe Hospital has not been subject to a final order or judgment in any licensure action.

2.) Criminal fines in cases involving a Federal or State health care offense;

Response

Erlanger Bledsoe Hospital has not been the subject of any criminal fines involving a Federal or State healthcare offense.

3.) Civil monetary penalties in cases involving a Federal or State health care offense;

Response

Erlanger Bledsoe Hospital has not been the subject of any civil monetary penalties involving a Federal or State healthcare offense.

4.) Administrative monetary penalties in cases involving a Federal or State health care offense;

Response

Erlanger Bledsoe Hospital has not been the subject of any administrative monetary penalties involving a Federal or State healthcare offense.

5.) Agreement to pay civil or administrative monetary penalties to the federal government or any state in cases involving claims related to the provision of health care items and services; and/or

Response

Erlanger Bledsoe Hospital has not been the subject of any administrative monetary penalties involving the Federal or State in cases involving claims related to the provision of health care items and services.

6.) Suspension or termination of participation in Medicare or Medicaid/TennCare programs.

Response

Erlanger Bledsoe Hospital has not been the subject of any suspension or termination of participation in Medicare or Medicaid/TennCare programs.

7.) Is presently the subject of/to an investigation, regulatory action, or party in any civil or criminal action of which you are aware.

Response

Erlanger Bledsoe Hospital has not been the subject of/to an investigation, regulatory action, or party in any civil or criminal action.

8.) Is presently subject to a corporate integrity agreement.

Response

Erlanger Bledsoe Hospital is not presently subject to a corporate integrity agreement.

6. Outstanding Projects

A. Complete the following chart by entering information for each applicable outstanding CON by applicant or share common ownership; and

Outstanding Projects					
CON Number	*Project Name*	*Date Approved*	*(*) Annual Progress Report(s) Due Date*	*Date Filed*	*Expiration Date*

(*) Annual Progress Reports - HSDA Rules require that an Annual Progress Report (APR) be submitted each year. The APR is due annually until the Final Project Report (FPR) is submitted (FPR is due within 90 days of the completion date and/or implementation of the project). Brief progress status updates are requested as needed. The project remains outstanding until the FPR is received.

Response

Outstanding Projects					
CON Number	*Project Name*	*Date Approved*	*(*) Annual Progress Report(s) Due Date*	*Date Filed*	*Expiration Date*
CN1601-002	Erlanger East Hospital – Level III NICU	04/27/2016	04/27/2017	04/24/2017	07/01/2019
CN1412-048	Erlanger East Hospital – Cancer Center & Linear Accelerator	03/25/2015	03/25/2017	04/17/2017	05/01/2018
CN1603-012	Erlanger Behavioral Health, LLC	08/24/2016	10/01/2017	07/03/2017	10/01/2019

B. Provide a brief description of the current progress, and status of each applicable outstanding CON.

Response

CN1601-002	Erlanger East Hospital is in process of implementation, providing education to staff and medical professionals, as well as evaluating minimum cost options to complete the project.
CN1412-048	A request for extension has been approved by the HSDA. Site clearing is in process.
CN1603-012	Construction has begun and is currently on schedule.

7. Equipment Registry – For the applicant and all entities in common ownership with the applicant.

A. Do you own, lease, operate and/or contract with a mobile vendor for a Computed Tomography scanner (CT), Linear Accelerator, Magnetic Resonance Imaging (MRI), and/or Positron Emission Tomographer (PET) ?

Response

Erlanger Health System, through it's member hospitals including Erlanger Bledsoe Hospital, owns and operates several pieces of major medical equipment, including Computed Tomography, Linear Accelerator, Magnetic Resonance Imaging, and Positron Emission Tomography.

B. If yes, have you submitted their registration to HSDA ? If you have, what was the date of submission?

Response

Registration was submitted on January 24, 2017.

C. If yes, have you submitted your utilization to Health Services & Development Agency ? If you have, what was the date of submission ?

Response

Utilization data was submitted on February 9, 2017.

(IV.) *QUALITY MEASURES*

Please verify that the applicant will report annually using forms prescribed by the Agency concerning continued need and appropriate quality measures as determined by the Agency pertaining to the certificate of need, if approved.

Response

Erlanger Sequatchie Valley Regional Hospital will report annually using forms prescribed by the *Agency* concerning continued need and appropriate quality measures, if approved.

(V.) *STATE HEALTH PLAN QUESTIONS*

T.C.A. § 68-11-1625 requires the Tennessee Department of Health's, Division of Health Planning, to develop and annually update the State Health Plan (found at http://www.tn.gov/health/topic/health-planning). The State Health Plan guides the State in the development of health care programs and policies and in the allocation of health care resources in the State, including the Certificate of need program. The 5 Principles For Achieving Better Health are from the State Health Plan's framework and inform the Certificate of Need program and its standards and criteria.

Discuss how the proposed project will relate to the 5 Principles For Achieving Better Health found in the State Health Plan.

1. **The purpose of the State Health Plan is to improve the health of the people of Tennessee.**

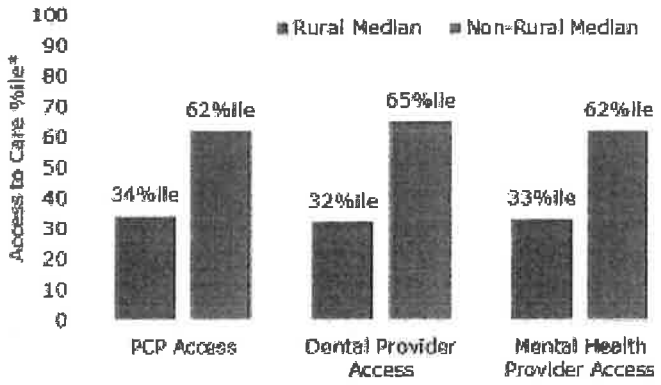
   Response

For overall rank pertaining to health outcomes, out of ninety-five (95) counties in Tennessee, Bledsoe County ranked number twenty (20) in 2013, and ranked seventeen (17) in 2017.

It should be noted that in 2013, *Erlanger Bledsoe Hospital* opened the first provider based emergency department in Tennessee which is part of a critical access hospital, in Dunlap, Sequatchie County, and we believe this ED, along with access to essential services, was instrumental to the improvement in health outcomes.

Further, the *Chartis Center For Rural Health* has illustrated the disparity of access to health services between rural and non-rural communities.

Access to Healthcare in Rural Hospital Communities



***Population Health metrics are percentile ranked for all acute care rural and non-rural providers by hospital service area such that lower ranks indicate greater population challenges.**

Not surprisingly, access to care for rural areas is essentially equivalent to half of the availability for non-rural areas.

The goal for *Erlanger Health System* is to provide a comprehensive system of care comprised of unduplicated services while also serving those who are currently under served and/or those who do not have the ability to pay for their services. As such, *Erlanger Sequatchie Valley Regional Hospital* is part of a long term plan to make services more accessible, and to ultimately improve the health of Tennesseans.

2. People in Tennessee should have access to health care and the conditions to achieve optimal health.

Response

Erlanger Sequatchie Valley Regional Hospital – Satellite ED will maintain access to emergency medical services for Bledsoe County, as part of a "community regional hospital". The goal of this project is to locate a satellite ED where it will be most accessible in a rural service area. It will be centrally located within Bledsoe County. Also, it will be part of the "system of care" which *Erlanger Health System* has developed.

3. Health resources in Tennessee, including health care, should be developed to address the health of people in Tennessee while encouraging economic efficiencies.

Response

As stated previously, the relocation and replacement of *Erlanger Bledsoe Hospital – Satellite ED* with *Erlanger Sequatchie Valley Regional Hospital – Satellite ED*, is simply more efficient than to renovate the current physical plant. Also, it places the provider based ED in a central location within the service area that will enable access to emergency medical services for the rural population.

4. People in Tennessee should have confidence that the quality of health care is continually monitored and standards are adhered to by providers.

Response

Erlanger Bledsoe Hospital, as a member facility of *Erlanger Health System*, has access to quality monitoring activities which most critical access hospitals do not. The applicant is accredited by *The Joint Commission* and is licensed by the *Tennessee Dept. of Health*. This monitoring consists of periodic review of quality indicators which are part of a robust program of quality improvement.

5. The state should support the development, recruitment, and retention of a sufficient and quality health workforce.

Response

Erlanger Health System, as the region's only academic medical center, has established strong long term relationships with the region's colleges, universities and clinical programs. *Erlanger* provides clinical sites for internships and rotation programs in nursing, radiology, respiratory, pharmacy and surgery technology, to name a few. It is also expected that *Erlanger Behavioral Health* will do so as well.

A number of regional universities offer Bachelor degree programs in nursing and physical therapy. *Erlanger* works closely with the *University of Tennessee at Chattanooga* to assist nurses transitioning from RN to BSN. Erlanger provides a teaching environment for staff as well with various on-the-job training opportunities (ex: CT for Radiologic Technologist, Certification for LPNs). Locally, two year degrees are available in many clinical allied health areas with additional programs offering advanced technical training in Radiological Imaging such as Nuclear Medicine, Diagnostic Ultrasonography, etc. *Erlanger Health System* participates with numerous schools that provide advanced training in the areas of nursing and allied health.

Erlanger has established strong long term relationships with the region's colleges, universities and clinical programs. *Erlanger* provides clinical sites for internships and rotation programs in nursing, radiology, respiratory care and pharmacy, to name a few. A number of regional universities offer Bachelor degree programs in nursing and physical therapy. Locally, two year degrees are available in many clinical allied health areas with additional programs offering advanced technical training in Radiological Imaging such as Nuclear Medicine and Diagnostic Ultrasonography.

The *University of Tennessee – College of Medicine* is co-located at *Erlanger* and includes training of senior medical students on clinical rotation as well as graduate medical education for training of residents and advanced fellowships in various medical specialties, including surgical specialties, as outlined below.

Residency Programs

- Emergency Medicine
- Family Medicine
- Internal Medicine

Obstetrics & Gynecology
Orthopedic Surgery
Pediatrics
Plastic Surgery
Surgery
Urology
Transitional Year

Fellowship Programs
Cardiovascular Disease
Colon & Rectal Surgery
Emergency Medicine
Gastroenterology
Gynecologic Surgery - Minimally Invasive
Neuro-Interventional Surgery
Orthopedic Trauma Surgery
Surgical Critical Care
Vascular Surgery
Ultrasound
Transitional Year

Erlanger Health System is also a member of the *Vanderbilt University Medical Center - Health Network*. This affiliation will further enhance our ability to provide state of the art research, education and training programs. Further, *Erlanger Health System* has also affiliated with *Technion Institute Of Technology*, in Haifa, Israel, for training of medical students, as well as graduate medical education, residency training and research. Increased opportunity exists in various medical specialties to potentially add to *Erlanger's* growing portfolio of medical research and training programs.

Erlanger Health System also participates with numerous schools that provide advanced training in the areas of nursing and allied health.

PROOF OF PUBLICATION

Attach the full page of the newspaper in which the notice of intent appeared with the mast and dateline intact or submit a publication affidavit from the newspaper that includes a copy of the publication as proof of publication of the letter of intent.

Response

Attached is a copy of the *Letter Of Intent* which was filed with the *Tennessee Health Services & Development Agency*. The original publication affidavit is also attached to this CON application.

NOTIFICATION REQUIREMENTS

(Applies only to Non-Residential Substitution-Based Treatment Centers For Opiate Addiction)

Note that T.C.A. § 68-11-1607(c)(9)(A) states that "... Within ten (10) days of the filing of an application for a nonresidential substitution-based treatment center for opiate addiction with the agency, the applicant shall send a notice to the county mayor of the county in which the facility is proposed to be located, the state representative and senator representing the house district and senate district in which the facility is proposed to be located, and to the mayor of the municipality, if the facility is proposed to be located within the corporate boundaries of a municipality, by certified mail, return receipt requested, informing such officials that an application for a nonresidential substitution-based treatment center for opiate addiction has been filed with the agency by the applicant."

Failure to provide the notifications described above within the required statutory timeframe will result in the voiding of the CON application.

Please provide documentation of these notifications.

Response

*** Not applicable. ***

DEVELOPMENT SCHEDULE

T.C.A. § 68-11-1609(c) provides that a Certificate of Need is valid for a period not to exceed three (3) years (for hospital projects) or two (2) years (for all other projects) from the date of its issuance and after such time shall expire; provided, that the Agency may, in granting the Certificate of Need, allow longer periods of validity for Certificates of Need for cause shown. Subsequent to granting a Certificate of Need, the Agency may extend a Certificate of Need for a period upon application and good cause shown, accompanied by a non-refundable reasonable filing fee, as prescribed by rule. A Certificate of Need which has been extended shall expire at the end of the extended time period. The decision whether to grant such an extension is within the sole discretion of the Agency, and is not subject to review, reconsideration, or appeal.

1. **Complete the Project Completion Forecast Chart on the next page. If the project will be completed in multiple phases, please identify the anticipated completion date for each phase.**

   Response

   The *Project Completion Forecast Chart* has been completed and appears on the following page.

2. **If the response to the preceding question *indicates that the applicant does not anticipate completing the project within the period of validity as defined in the preceding paragraph*, please state below any request for an extended schedule and document the "good cause" for such an extension.**

   Response

   *** Not Applicable. ***

PROJECT COMPLETION FORECAST CHART

Assuming the CON approval becomes the final Agency action on the date listed in item 1 below, indicate the number of days from the HSDA decision date to each phase of the completion forecast.

PHASE		Days Required	Anticipated Date (MONTH / YEAR)
1.	Initial HSDA decision date.		12 / 17
2.	Architectural and engineering contract signed.	15	01 / 18
3.	Construction documents approved by the *Tennessee Dept. Of Health.*	180	07 / 18
4.	Construction contract signed.	30	08 / 18
5.	Building permit secured.	30	09 / 18
6.	Site preparation completed.	60	11 / 18
7.	Building construction commenced.	-	11 / 18
8.	Construction 40 % complete.	120	03/ 19
9.	Construction 80 % complete.	120	07 / 19
10.	Construction 100 % complete (approved for occupancy.	60	09 / 19
11.	*Issuance of license.	30	10 / 19
12.	*Initiation of service.	-	10 / 19
13.	Final Architectural Certification Of Payment.	30	12 / 19
14.	Final Project Report Form (HR0055).	60	02 / 20

(*) For projects that do NOT involve construction or renovation, please complete items 11 and 12 only.

NOTE – If litigation occurs, the completion forecast will be adjusted at the time of the final determination to reflect the actual issue date.

SEP 11'17 PM12:21

A F F I D A V I T

STATE OF TENNESSEE

COUNTY OF HAMILTON

Joseph M. Winick, being first duly sworn, says that he / she is the applicant named in this application or his / her / it's lawful agent, that this project will be completed in accordance with the application, that the applicant has read the directions to this application, the Rules of the Health Services & Development Agency, and and T.C.A. § 68-11-1601, *et seq*, and that the responses to this application or any other questions deemed appropriate by the Tennessee Health Services & Development Agency are true and complete.

SIGNATURE

SWORN to and subscribed before me this 7 of September (Month), 2017 (Year), a Notary Public in and for the State of Tennessee, County of Hamilton.

Shelia Hall
NOTARY PUBLIC

My commission expires 6 9 (Month / Day), 2018.

SHELIA HALL
STATE OF TENNESSEE NOTARY PUBLIC
HAMILTON COUNTY

TABLE OF ATTACHMENTS

Proof Of Publication

HSDA - Letter Of Intent
HSDA - Publication Of Intent
Affidavit Of Publication

Description	Section / Item
ARTICLE - Rural Hospitals Across Tennessee At Risk Of Closing	A-3
ARTICLE - State By State Breakdown Of 80 Rural Hospital Closures	A-3
ARTICLE - Textile Mill Will Add 1,000 Jobs In Pikeville	A-3
REPORT - Rural Relevance 2017: Assessing The State Of Rural Healthcare In America	A-3
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ATTACHMENTS

Proof Of Publication

HSDA - Letter Of Intent
HSDA - Publication Of Intent
Affidavit Of Publication

PUBLICATION OF INTENT

TENNESSEE HEALTH SERVICES & DEVELOPMENT AGENCY

Instructions To Newspaper

The following shall be published in the "Legal Notices" section of the newspaper in a space no smaller than four (4) inches.

NOTIFICATION OF INTENT TO APPLY FOR A CERTIFICATE OF NEED

This is to provide official notice to the Health Services & Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 *et. seq.*, and the Rules of the Health Services & Development Agency, that Erlanger Sequatchie Valley Regional Hospital, with an ownership type of governmental, and to be managed by itself, intends to file an application for a Certificate of Need ("CON") to construct a provider based (free standing) emergency department in Pikeville, Bledsoe County, Tennessee.

This facility will replace the existing Erlanger Bledsoe Hospital – Provider Based ED, located at 16931 Rankin Avenue, Dunlap, TN 37327. The new Erlanger Sequatchie Valley Regional Hospital – Provider Based ED will be located at 553 U.S. Highway 127 Bypass, Pikeville, Bledsoe County, Tennessee, 37367, otherwise described as beginning at an iron rod set situated in the northeastern corner of the property at South 18 degrees 34 minutes 40 seconds West, 1,128.65 feet to a monument situated in the right of way of the U.S. Highway 127 Bypass; then South 17 degrees 4 minutes 0 seconds East 792.01 feet to an iron rod set; then North 17 degrees 4 minutes 0 seconds East 560.61 feet to the beginning.

A companion CON application will be filed with the Health Services & Development Agency for the new Erlanger Sequatchie Valley Regional Hospital in Dunlap, Sequatchie County, Tennessee, to replace the existing Erlanger Bledsoe Hospital at 71 Wheelertown Avenue, Pikeville, Bledsoe County, Tennessee.

The total project cost is estimated to be $ 4,388,481.00.

The anticipated date of filing the application is September 12, 2017.

The contact person for this project is Joseph M. Winick, Sr. Vice President, Erlanger Health System, 975 East 3rd Street, Chattanooga, Tennessee, 37403, and by phone at (423) 778-7274.

Upon written request by interested parties, a local Fact-Finding public hearing shall be conducted. Written requests for hearing should be sent to:

Health Services & Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

Pursuant to T.C.A. § 68-11-1607(c)(1): (A) Any health care institution wishing to oppose a Certificate Of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

Description	Section / Item
ARTICLE - Rural Hospitals Across Tennessee At Risk Of Closing	A-3
ARTICLE - State By State Breakdown Of 80 Rural Hospital Closures	A-3
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Erlanger Letter To CMS Requesting Approval Of Hospital Relocation	A-3

Rural Hospitals Across Tennessee At Risk Of Closing

Emergency At The E.R.

BY: Chris Conte
POSTED: 4:22 PM, Jul 25, 2017
UPDATED: 8:36 PM, Jul 25, 2017

Share Article

PARSON, Tenn. - With barely 11,000 residents you could consider Decatur County to be on the front lines of a battle being fought across rural America right now, one that small town hospitals are repeated losing putting patients in life or death situations.

Built in 1964, Decatur County General Hospital lies just a few blocks from the center of the town of Parsons. The "L" shaped building is currently running with a bare minimum staff, 80 full time employees and just one doctor. Hospital officials have worked tirelessly over the last few months, trimming the staff of nurses and lab technicians down from 110 people in an effort to minimize costs. The county mayor here estimates Decatur General lost about $200,000 last year, this life line to so many is currently on life support and in danger of closing.

"If this goes away there are so many people who won't get the care they need," says Paulette Johnson who was at the emergency room on a recent Tuesday having x-rays done on her neck.

The 67-year-old lives in Scotts Hill, Tennessee, a town that lies about 20 minutes away from the emergency room at Decatur County General Hospital. If this hospital shuts its doors, it would take more than an hour for Paulette to get to the next closest emergency room.

That kind of drive could mean the difference between life or death in an emergency.

close

"They can save your life here, you're gonna lose your life if you have to go further," Paulette says.

Decatur County General is hardly alone in the struggle to stay open. Nationwide 81 rural hospitals have closed since 2010. Nine of those closures have happened in Tennessee, county run hospitals from the eastern mountains to the Mississippi River have disappeared. The only state with more rural hospital closures than Tennessee is Texas, where in 2013 an 18-month old died after being rushed to an emergency room that her parents didn't realize had closed.

List of hospitals closed in Tennessee:

- Haywood Park Community Hospital – Haywood County
- Gibson General Hospital – Gibson County
- Humboldt Medical Center – Gibson County
- Tennova Healthcare McNairy Regional – McNairy County
- United Regional Medical Center – Coffee County
- Parkridge West – Marion County
- St. Mary's – Scott County
- Starr Regional – McMinn County
- Copper Basin Medical Center - Polk County

NEWS STORIES

Camp Bow Wow Smyrna reminds pet owners to...

Animal lovers are reminded to keep an eye on their pets as temperatures continue to soar in the Middle Tennessee area.

I-440 West Blocked After Truck Spills Debris

A portion of westbound Interstate 440 has been partially blocked after a vehicle overturned and spilled debris onto the roadway.

close

State-by-state breakdown of 80 rural hospital closures

Written by Ayla Ellison (Twitter | Google+) | August 15, 2017 | Print | Email

Of the 26 states that have seen at least one rural hospital close since 2010, those with the most closures are located in the South, according to research from the North Carolina Rural Health Research Program.

Thirteen hospitals in Texas have closed since 2010, the most of any state. Tennessee has seen the second-most closures, with eight hospitals closing since 2010. In third place is Georgia with six closures, followed by Alabama and Mississippi, which have each seen five hospitals close over the past six years.

Listed below are the 80 rural hospitals that closed between January 2010 and July 2017, as tracked by the NCRHRP. For the purposes of its analysis, the NCRHRP defined a hospital closure as the cessation in the provision of inpatient services. As of July, all of the facilities listed below no longer provided inpatient care. However, many of them still offered other services, including outpatient care, imaging, emergency care, urgent care, primary care or skilled nursing and rehabilitation services. This list does not include hospitals that have closed and re-opened.

Alabama
Chilton Medical Center (Clanton)
Elba General Hospital
Florala Memorial Hospital
Randolph Medical Center (Roanoke)
Southwest Alabama Medical Center (Thomasville)

Arizona
Cochise Regional Hospital (Douglas)
Florence Community Healthcare
Hualapai Mountain Medical Center (Kingman)

California
Colusa Regional Medical Center
Corcoran District Hospital
Kingsburg Medical Center

Florida
Campbellton-Graceville Hospital

Georgia
Calhoun Memorial Hospital (Arlington)
Charlton Memorial Hospital (Folkston)
Hart County Hospital (Hartwell)
Lower Oconee Community Hospital (Glenwood)
North Georgia Medical Center (Ellijay)
Stewart-Webster Hospital (Richland)

Illinois
St. Mary's Hospital (Streator)

Kansas
Central Kansas Medical Center (Great Bend)
Mercy Hospital Independence

Kentucky
New Horizons Medical Center (Owenton)
Nicholas County Hospital (Carlisle)
Parkway Regional Hospital (Fulton)
Westlake Regional Hospital (Columbia)

Maine
Parkview Adventist Medical Center (Brunswick)
Southern Maine Health Care – Sanford Medical Center
St. Andrews Hospital (Boothbay Harbor)

Massachusetts
North Adams Regional Hospital

Michigan
Cheboygan Memorial Hospital

Minnesota
Albany Area Hospital
Lakeside Medical Center (Pine City)

Mississippi
Kilmichael Hospital
Merit Health Natchez – Community Campus
Patient's Choice Medical Center of Humphreys County (Belzoni)
Pioneer Community Hospital of Newton
Quitman County Hospital (Marks)

Missouri
Parkland Health Center – Weber Road (Farmington)
Sac-Osage Hospital (Osceola)
SoutheastHEALTH Center of Reynolds County (Ellington)

Nebraska
Tilden Community Hospital

Nevada
Nye Regional Medical Center (Tonopah)

North Carolina
Davie Medical Center-Mocksville
Blowing Rock Hospital
Vidant Pungo Hospital (Belhaven)
Yadkin Valley Community Hospital (Yadkinville)

Ohio
Doctors Hospital of Nelsonville
Physicians Choice Hospital-Fremont

Oklahoma
Epic Medical Center (Eufaula)

Memorial Hospital & Physician Group (Frederick)
Muskogee Community Hospital

Pennsylvania
Mid-Valley Hospital (Peckville)
Saint Catherine Medical Center Fountain Springs (Ashland)

South Carolina
Bamberg County Memorial Hospital
Marlboro Park Hospital (Bennettsville)
Southern Palmetto Hospital (Barnwell)

South Dakota
Holy Infant Hospital (Hoven)

Tennessee
Copper Basin Medical Center (Copperhill)
Gibson General Hospital (Trenton)
Haywood Park Community Hospital (Brownsville)
Humboldt General Hospital
Parkridge West Hospital (Jasper)
Starr Regional Medical Center-Etowah
McNairy Regional Hospital (Selmer)
United Regional Medical Center (Manchester)

Texas
East Texas Medical Center-Clarksville
East Texas Medical Center-Gilmer
East Texas Medical Center-Mount Vernon
East Texas Medical Center-Trinity
Good Shepherd Medical Center (Linden)
Gulf Coast Medical Center (Wharton)
Hunt Regional Hospital of Commerce
Lake Whitney Medical Center (Whitney)
Nix Community General Hospital (Dilley)
Renaissance Hospital Terrell
Shelby Regional Medical Center
Timberlands Hospital (Crockett)
Wise Regional Health System-Bridgeport

Virginia
Lee Regional Medical Center (Pennington Gap)

Wisconsin
Franciscan Skemp Medical Center (Arcadia)

More information on the rural hospitals that have closed since 2010 can be accessed here.

More articles on healthcare finance:

Quorum Health sees net loss narrow to $30.6M, plans more hospital sales
Tenet's net loss balloons to $56M on lower patient volume
Physician advocates: 'We can only judge CHS by its actions, not its words'

TUESDAY
JULY 25, 2017

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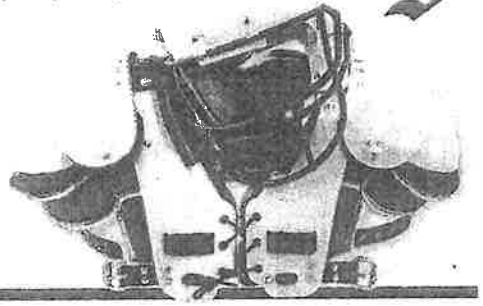
Chattanooga Times Free Press



Monday prep tour: First practice day in pads

IN SPORTS › D1

Mocs 'D' strong in practice opener

IN SPORTS › D1

Hixson home gets a shot on 'House Hunters'

IN LIFE › E1

Textile mill will add 1,000 jobs in Pikeville

Largest investment ever in Bledsoe County called part of manufacturing renaissance

BY DAVE FLESSNER
STAFF WRITER

PIKEVILLE, Tenn. — Twelve years after Bledsoe County lost its biggest private employer when Dura Automotive shut down its 580-employee plant here, the shuttered plant soon will reopen as a textile operation employing nearly twice as many people.

Textile Corp. of America announced Monday it will make the biggest private investment ever in Bledsoe County, spending $27.1 million to buy and upgrade the vacant 186,000-square-foot factory building in Pikeville, the county seat of Bledsoe County, with a population last year estimated at only 1,648 residents.

The new company, which is owned by Chattanooga developer and businessman Ed Cagle, plans to start production of apparel, bedding and linens this fall. Officials said they hope to quickly increase the staff to 1,000 employees and begin hiring and training workers in the next month or so.

"When it came time to bring textile manufacturing back to America again, this community was hands down the first choice," said Troy King, a former attorney general for Alabama who is chief legal counsel for the company. "We believe this represents the renaissance of America, the return of America as a global manufacturing center."

The textile manufacturer will locate its headquarters on the 16-acre site here and install what it says is state-of-the-art machinery to produce industrial and institutional textile products, including apparel, kitchen linens and bedding for the healthcare and hospitality industries. The leadership of the new business has more than four decades of experience working around the globe, and Cagle said in a statement he is eager to bring production back to the United States.

"We are proud to call Pikeville, Tenn., home to our new mill," said Cagle, owner of Cagle & Associates in Chattanooga and a builder of Family Dollar stores and other commercial projects across the country. "Millions of dollars of investment and the creation of thousands of jobs will be transformative for this county and region."

PHOTO BY DAVE FLESSNER

Tennessee Gov. Bill Haslam, center, talks about the $27.1 million investment a new textile company is making in Pikeville to create 1,000 jobs. With Haslam, from left, are Pikeville Mayor Philip "Winky" Cagle, Bledsoe County Mayor Gregg Ridley and Troy King, chief legal counsel for Textile Corporation of America.

The company looked at sites in several states for the textile plant before buying the abandoned Dura Automotive facility earlier this month for $850,000.

"A thousand jobs in any community is big news, but it is especially welcome in Bledsoe County," Tennessee Gov. Bill Haslam said in announcing the project Monday afternoon at the plant site. "I know some people worry that we no longer make things in America, but we still make things in Tennessee, and this is a great example for Bledsoe County and all of Tennessee."

King said the new plant should be in production by October.

"It's a very ambitious and aggressive timeline, but we're ready to go to work and ready to put people to work," said King, who said the company soon will begin screening applicants through the state's Career Centers. "If it is made out of cotton and textiles, we can make it here. We have a president who is putting an emphasis on "Made in America," and we think the timing is right for this now."

Unemployment in Bledsoe County fell in May to 4.5 percent, its lowest level in nearly 15 years. But Bledsoe still had the fifth highest jobless rate of Tennessee's 95 counties in the most recent state jobs report.

Bledsoe County Mayor Gregg Ridley said he has been working for virtually his entire term as county mayor to recruit a replacement for Dura Automotive, which shut down shortly after he became mayor and helped push the county's jobless rate up during the Great Recession to as high as 14.1 percent.

Ridley said the biggest private employer of Bledsoe County residents today is the La-Z-Boy plant in Rhea County, but the Textile Corporation of America should soon become the biggest private employer in the county. With a monthly payroll of more than $1 million, Ridley said the new plant should pump more than $35 million a year into the local economy.

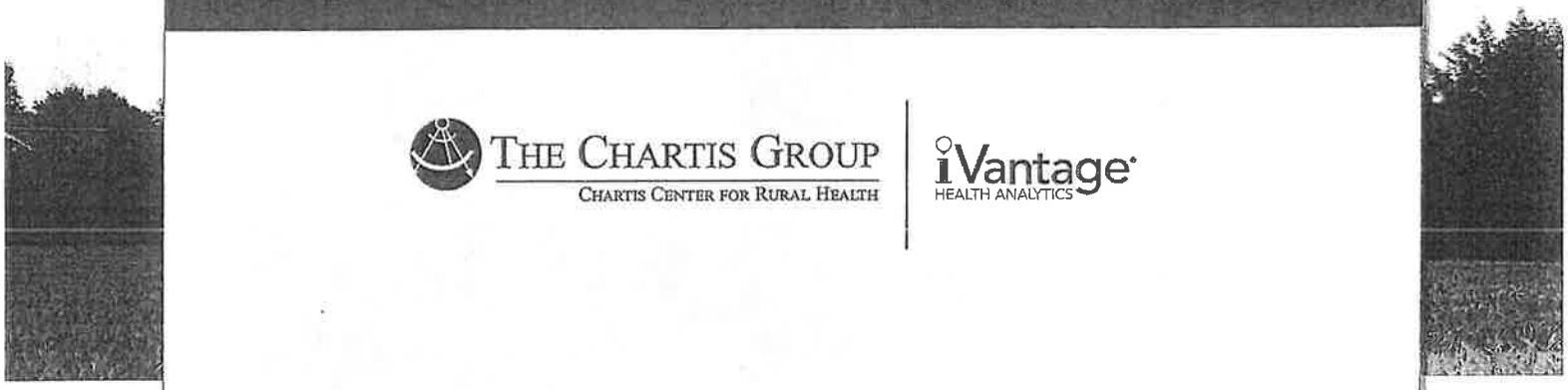
With its corporate headquarters and 1,000 jobs, Textile Corporation of America will qualify for state-funded job training, infrastructure and headquarters incentives, and TVA will offer assistance through its economic development programs. Bob Rolfe, commissioner of economic and community development, said the investment also helps the Haslam administration's effort to spread economic growth of the state into rural areas. But Rolfe said it is too early to detail all of the tax breaks and financial incentives state and local governments offered the business to lure it to Pikeville.

The project represents one of the biggest new textile job generators so far in 2017 and is part of a growing trend of "re-shoring" investment back into the United States after decades of moving textile and apparel production offshore where land and labor is usually far cheaper.

Jeff Price, president of the specialty fabrics division of Milliken & Co. and chairman of the National Council of Textile Organizations, said the U.S. textile industry "is on sound footing" and growing again after decades of decline. Since 2009, the industry has grown more than 14 percent, Price said.

"Emerging from the depths of a severe national recession, the U.S. textile sector has rebounded," he wrote last year in the industry publication Textile World. "Now, the challenge is both to sustain this impressive recovery and to find viable ways to generate a new era of growth."

Contact Dave Flessner at dflessner@timesfreepress.com or 423-757-6340.



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Research

Rural Relevance 2017: Assessing the State of Rural Healthcare in America

Author: Michael Topchik

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Foreword

The 2017 Rural Relevance Study arrives at a time of great uncertainty for all healthcare providers. Congress has taken the first step toward dismantling the Patient Protection and Affordable Care Act (ACA) and House Republicans have put forward legislation to replace it with The American Health Care Act (AHCA), a hybrid model that seeks to maintain some features of the ACA while repealing others. Key elements of this proposed legislation would impact rural providers either directly or indirectly, including:

- **Reversal of ACA's cuts in federal disproportionate share hospital (DSH) Medicaid payments:** The proposed legislation reverses cuts to DSH payments, a funding stream that supports hospitals which treat an unusually large share of uninsured patients and patients covered under Medicaid. Many rural hospitals are reliant on Medicaid DSH payments as a source of revenue and will benefit from stabilization in funding.
- **An increase in the uninsured:** Several provisions from the ACA may be impacted, including the repeal of the individual mandate and, more importantly, changes to the premium support for individuals purchasing coverage on the non-group market. The Congressional Budget Office (CBO) estimates that as a result, 24 million more people may be uninsured by 2026 – a projection criticized by HHS Secretary Price. However, most believe that the number of uninsured is likely to increase and believe that under the proposed legislation, poorer, older adults would be the most impacted as they are expected to have a harder time qualifying for tax credits. Additionally, the new legislation would enable higher premium variance by age, moving from a 3:1 allowable age-based premium difference to a 5:1 differential. With a disproportionately older percentage of the population living in rural areas and fewer able to afford health coverage under the AHCA, this would ultimately increase the burden on rural providers.
- **Rolling-back Medicaid expansion and potential long-term funding constraints through Medicaid restructuring:** States may choose to maintain current funding associated with Medicaid expansion through 2020 (capped at 2016 rates). However, the CBO projects some states will consider dropping the expansion as federal dollars "dry up" under the AHCA. As a result, some rural populations will learn how far their coverage can stretch as federal dollars are first capped and then frozen.

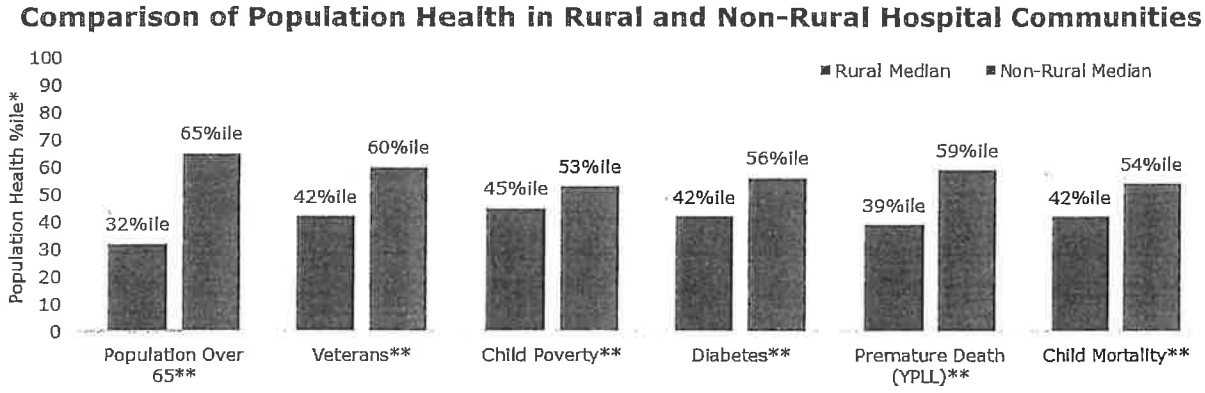
The uncertainty surrounding the future of the ACA/AHCA will likely continue to be unsettling for rural providers – especially when the potential for changes in legislation threatens financial viability and stability. The Chartis Center for Rural Health (CCRH) and iVantage Health Analytics have devoted significant resources to evaluating the state of the rural health safety net and modeling the impact of potential policy changes on rural providers. In this state of uncertainty, the Rural Relevance Study offers a unique lens into the state of rural healthcare, the value the safety net provides, and the opportunities for the future.

The State of Rural Healthcare

Rural Populations Suffer Many Health Disparities

As part of the 2017 study, CCRH explored the intersection of rural provider performance and the socioeconomic challenges and health disparities faced by rural communities. Our population health assessment measures the health status of rural populations by evaluating health outcomes, quality of care, access to care, health behaviors, and social, economic, and environmental determinants of health. Using nearly 70 metrics, the CCRH quantified the health status of each rural provider's community.

Our research validates the hypothesis that rural healthcare providers serve populations which are not only socioeconomically disadvantaged but also suffer from numerous health disparities and poorer outcomes than non-rural communities (Figure 1).



*Population Health metrics are percentile ranked for all acute care rural and non-rural providers by hospital service area such that **lower ranks indicate greater population challenges**.
**Lower percentile scores indicate higher density (i.e. providers serving a greater proportion of individuals over 65 receive lower scores).

Figure 1. Rural hospitals serve populations that suffer from various health disparities and poorer outcomes than non-rural providers.

While rural populations are equally challenged with baseline disparities, there are significant variations by region, state and even within communities in the same state. Highlighting these variations at a state level and then searching exceptions creates an opportunity to learn more about the unique health status of each community and provides valuable information to target services and funding to meet the highest needs of each population.

Two Distinct and Overlapping Populations Drive Up Demand

Seniors

According to the US Census Bureau, **adults in rural areas are older** than those living in non-rural areas, with a median age of 51, compared to age 45 in non-rural areas. Hospitalization rates and lengths of stay increase with age among adults, peaking for those over 65.[1] This creates increased demand for healthcare in rural areas. As a result, the majority of rural providers serve a greater proportion of patients over the age of 65 than two-thirds of all U.S. acute care hospitals.

The number of Americans over 65 is expected to increase from nearly 50 million to more than 80 million by 2050, largely driven by baby boomers.[2] In fact, seniors are expected to outnumber children under 5 for the first time in history by 2020.[3] Given the healthcare consumption, complexity of care needed, and associated costliness of healthcare services, this aging of the population will exert increasing operational, clinical and financial pressures on rural providers.[4]

Veterans

A disproportionate number of the nation's veterans live in rural and non-metropolitan counties. Nearly three-quarters of rural hospitals **serve a greater proportion of military veterans than the median non-rural provider.** Veterans living in these rural areas may need to travel greater distances to access a VHA facility, so rural hospitals are often called upon to fill a local access void. Of the 5.3 million veterans residing in rural America, 41 percent struggle with service-related disabilities, making access to quality healthcare imperative for these individuals.[5] Rural veterans utilize inpatient, emergency department, physician office visit and behavior health services at higher rates than non-veterans and more than urban veterans.[6]

Prevalence of Disease Combined with Less Access to Care

This year's research into rural healthcare revealed that rural communities have a higher burden of disease (including preventative diseases) and yet the supply of physicians and therefore access to healthcare is lower than in non-rural communities. This combination of a higher disease rate and lower access to care isn't surprising given the geographic distribution of populations across rural America. It is, however, an alarming trend and one that could be contributing to the higher premature death rates and child mortality rates in rural communities.

Rural hospitals **serve communities with greater rates of diabetes**, the seventh-leading cause of death in the nation.[7] Several factors contributing to diabetes such as obesity, physical inactivity, and a lack of exercise are more prevalent in rural communities, according to research.[8] The American Diabetes

[1] Agency for Healthcare Research and Quality, 2012.
[2] U.S. Census Bureau, 2014.
[3] U.S. Census Bureau, 2016.
[4] Department of Health and Human Services, 2011.
[5] National Rural Health Association, 2017.
[6] Variation in Utilization of Health Care Services for Rural VA Enrollees with Mental Health-Related Diagnoses, 2015.
[7] Center for Disease Control and Prevention, 2016.
[8] Robert Wood Johnson Foundation, 2013.

Association estimates the total cost of diabetes has risen from $174 billion in 2007 to $245 billion in 2012, a 41 percent increase. Patients with diagnosed diabetes incur average medical expenditures of about $13,700 per year. Particularly prevalent in rural America, rural hospitals are on the frontline in providing diabetic screening and care for populations which may not have access to primary or specialty care.

America is in the midst of **an opioid epidemic** that affects all income levels, educational backgrounds and geographies. However, specific demographic and socioeconomic conditions can lead to increased risk behaviors, especially opioid and other drug abuse. While this is more common among the uninsured and impoverished, the research shows significant variation.

According to the Centers for Disease Control and Prevention (CDC), the rate of death from opioid-related overdoses is 45 percent higher in **nonmetropolitan counties**.[1] Many rural emergency services may lack the resources to respond quickly and effectively. Rarely are highly-trained paramedics the first responders in rural communities. In addition, distances in rural geographies may mean longer wait times for critical interventions such as injectable antidotes like Naloxone.[2]

Rural communities are also generally isolated from treatment facilities and addiction counseling. Nationwide, only 11 percent of patients seeking addiction treatment receive care. Further, the distribution of this treatment is uneven. In those states which expanded Medicaid (a disproportionately important source of health coverage for rural populations), a higher proportion of buprenorphine prescriptions (an important therapy to wean patients off opioids) is covered, compared to those states which did not expand Medicaid.[3]

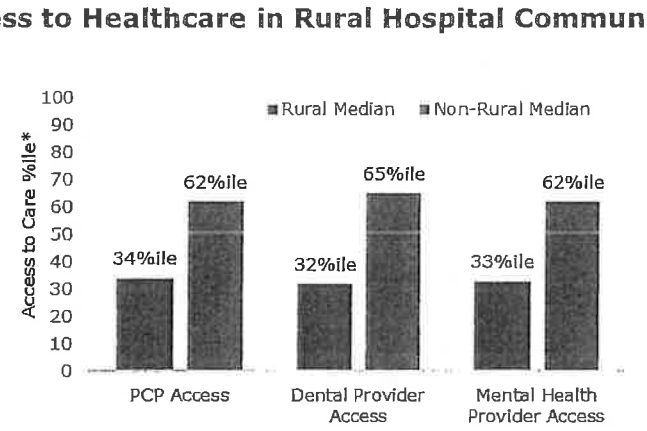
Last, the cost of providing lifesaving injectable antidote drugs such as Naloxone have skyrocketed, putting rural providers in the difficult position of providing more expensive therapies in the hands of EMS with little opportunity to recoup that cost, given the lack of commercial insurance or even Medicaid coverage in many rural communities.[4]

Thus, the lack of expedient access to advanced Emergency Medical Services, the lack of appropriate behavioral health/addiction treatment services, and the role Medicaid payments play in these interventions, combined with the skyrocketing costs of important life-saving and treatment therapies, places rural populations in the crosshairs of the opioid epidemic.

The burden of disease on rural communities is not being met with the **appropriate level of access** (Figure 2). Plagued by a physician workforce shortage, rural communities struggle to receive primary care, dental care and behavioral healthcare. This is exacerbated by geographic isolation, limited public transportation, fewer employment opportunities and limited health insurance coverage.[5] The patient-to-primary care physician ratio in rural areas is 39.8 physicians per 100,000 people, compared to 53.3 physicians per 100,000 in non-rural areas. Eighty-five percent of rural counties are designated as primary care Health Professional Shortage Areas (HPSAs), some with persistent whole county shortages.[6] This uneven distribution of physicians has an impact on the health of a population, as they lack access to preventative care as well as other types of ambulatory care. Further straining these rural access trends is

[1] Center for Disease Control and Prevention, 2015.
[2] Rural Health Information Hub, The Rural Monitor, May 18, 2016.
[3] Use of Opioid Recovery Medications, Sept, 2016.
[4] Patients get hooked on opioid overdose antidote, then prices skyrocket, Kaiser Health News, 2017.
[5] National Rural Health Association, 2017.
[6] Persistent Primary Care Health Professional Shortage Areas (HPSAs) and Health Care Access in Rural America, 2009.

the uneven aging of the provider workforce, where there are a greater proportion of providers nearing retirement.[1]



*Population Health metrics are percentile ranked for all acute care rural and non-rural providers by hospital service area such that **lower ranks indicate greater population challenges**.

Figure 2. Communities served by rural providers have less access to healthcare than non-rural areas. At the median, rural hospital communities rank in the bottom third with respect to primary, dental and mental healthcare access when compared to all acute care hospitals nationally on a 0-100 percentile scale.

Population Health Chart Book: National maps for each of the population health indicators explored in the study, as well as some state versus state comparisons are available at iVantageINDEX.com. View the population health chart book here.

The Rural Health Safety Net Remains Under Financial Pressure

The closure of 80 rural hospitals since 2010 underscores the challenges faced by rural providers, and research indicates that many more are struggling to stay open.[2] This is an indication that the rural health safety net continues to unravel, putting the mission to care for rural populations in jeopardy in a number of states.

Forty-one percent of rural hospitals operate at a negative margin. Figure 3 visualizes those facilities operating at negative margins in two cohorts (i.e. <3 percent and <0 percent), overlaid with rural providers which are achieving positive margins.

[1] The Aging of the Primary Care Physician Workforce, 2009.
[2] UNC Cecil G. Sheps Center for Health Services Research.

Rural Hospital Operating Margins

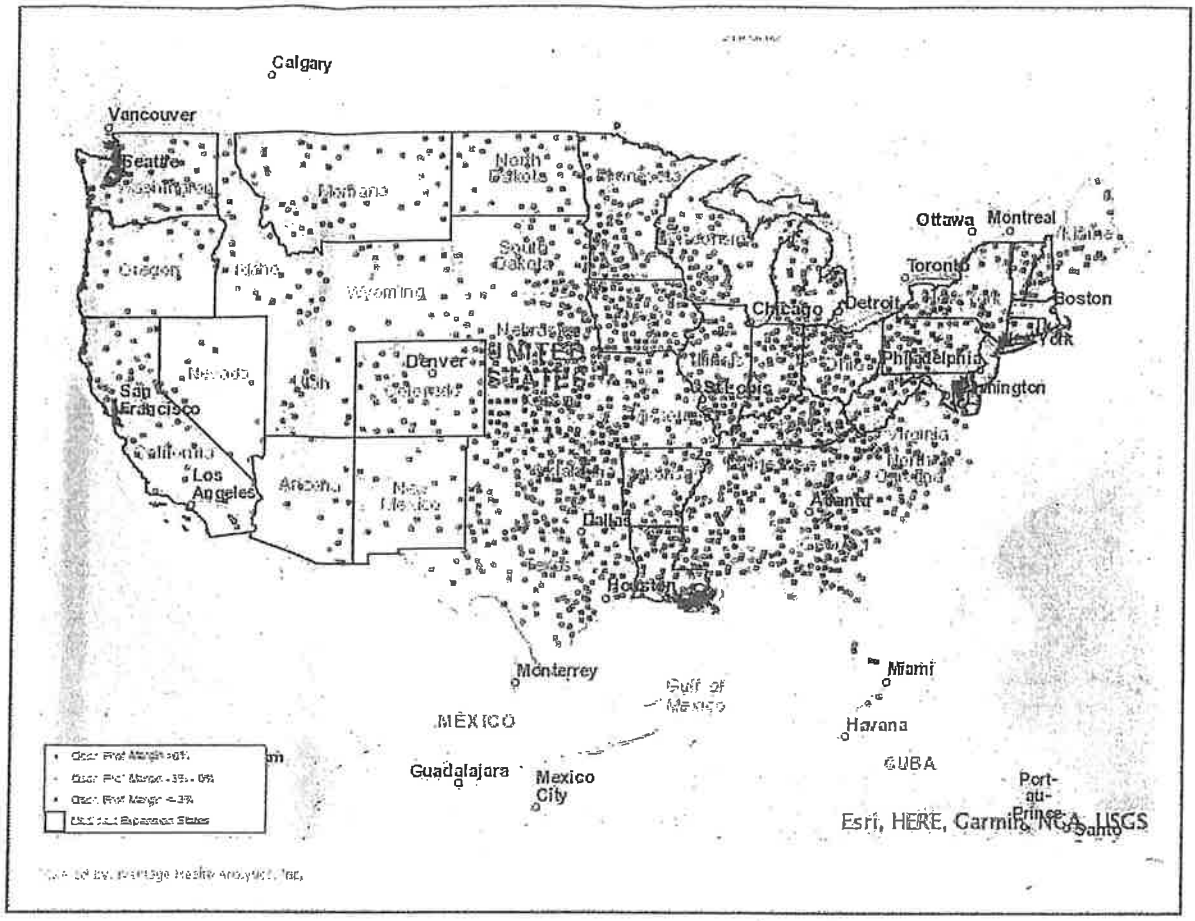


Figure 3. Each rural hospital across the country is point located in green if having a positive 2015 operating profit margin, orange if having a negative operating profit margin not exceeding -3 percent, and in red if having an operating profit margin below -3 percent.

Research Note: Rural hospital operating margins in Medicaid expansion states are statistically higher than rural hospitals in states that did not expand Medicaid. Contact CCRH for detailed metrics on your state.

Numerous factors are at play in each state which may have an impact on rural operating margins. These factors include:

- Payor mix and percentage of uninsured population
- Allowable cost-based Medicare reimbursement
- State expanded Medicaid as part of the ACA*
- Prevalence of competition and the rate of out-migration of patients seeking care in non-rural settings

- Employment rate and related availability of employer-sponsored commercial insurance
- Payor negotiated rates
- Availability of primary care
- Underlying population health and health disparities

Additionally, the healthcare industry's transition from volume to value has put increased pressure on hospital margins for many providers and a renewed focus on cost management to maintain positive margins. Jamie Orlikoff, a health governance expert, recommends that the industry work to take 5-6 percent of costs out of the system and reach a five-year target of 25-30 percent cost reduction.[1]

Cost containment is particularly challenging for Critical Access Hospitals (CAHs), currently receiving special cost-based reimbursement from Medicare. This system of reimbursement was created to ensure access to crucial services in rural communities despite not having the patient volumes to support those services in a market-based environment. This reimbursement policy has been successful in helping preserve access to care in rural America but changes to it could dramatically shift the current state.

While all hospitals strive to provide the best clinical care at the lowest cost, rural hospitals with cost-based reimbursements are not incentivized to focus on cost management. Nonetheless, benchmarks from the top performing rural hospitals reveal substantially lower cost positions when compared to their rural health peers nationally. The study offers a detailed examination of top hospital performance for Critical Access Hospitals and Rural and Community Hospitals.

Alternative payment models including Accountable Care Organizations (ACOs), which many providers now participate, make it difficult for CAHs as it introduces competing incentives. In capitated payment environments, it can become challenging to work across the continuum of care for rural providers that may have inflated cost structures to maintain access to low volume services. For ACOs that need to better manage costs across the continuum of care, patients may be redirected away from rural access points. Conversely, many types of care should be provided locally to offer a better patient experience at a lower cost, which is an area of intense focus for ACOs that include rural providers. These dynamics are driving questions about what is the right care model for covered lives within rural communities. The answer to this question is a critical one and the opportunities for innovation are exciting but the economics of new care models could very well put additional financial pressure on rural providers.

The consumer market is also adding pressure for hospitals to reduce costs as high-deductible plans shift the first out-of-pocket dollars to the consumer. Rural patients with high-deductible plans are becoming more price sensitive and showing a willingness to travel greater distances to reduce their healthcare costs. Rural hospitals therefore need to focus on improving their efficiency as lower volumes often equate to higher variable costs.

Additionally, employers are partnering with payors to form narrow networks of preferred providers. These providers are preferred by the market because they offer exceptional value and deliver quality care at the lowest cost. Rural hospitals must strive to be relevant and gain in-network status by defending and reducing their costs while continuously improving the quality of care in the face of these and other market forces.

[1] Presentation at American Hospital Association Rural Health Care Leadership Conference, February 7, 2015.

Policy Changes Impact Rural Providers

In addition to the current market forces that effect rural health operating margins, there are a number of policy changes already impacting the financial health of rural providers and a few which remain in question given the new administration in Washington. For this study, we analyzed seven current and proposed policies and their impact on rural providers, including: Sequestration, Bad Debt, CAH Reimbursement, PPS Coding Offset, Value-Based Purchasing, Medicaid Expansion, and Alternative Care Models. The methodology for the impact calculations below is available here.

State Snapshots: What's the impact of policies on rural healthcare and communities in your state? Snapshots for all states are available on our web site.

Rural Pressure Point: Sequestration

In March 2013, a range of Federal spending cuts went into effect. The cuts, commonly referred to as sequestration, included a planned two percent cut in almost all Medicare spending. The Congressional Budget Office projected that the cuts would total $123 billion over a 10-year period.

The estimated community impact of the sequestration over 10 years, based upon 2015 cost report data is:

- **$3.5 billion** in lost Medicare reimbursement among rural hospitals
- **153,000 jobs lost** in rural hospitals and communities
- **$18.0 billion** GDP loss

While the impact of sequestration impacts all hospitals with reimbursements for Medicare beneficiaries, the cuts are disproportionately harmful to rural providers. First, rural providers receive significantly more government reimbursement (Medicare and Medicaid) than non-rural counterparts, and these reimbursements tend to yield lower payments per case when compared with commercial payors. Second, rural hospitals' razor-thin or negative margins leave little room to absorb any reduction in revenues. The state-by-state impact is not evenly distributed - as is the case with many policy changes (see map on page 7).

Rural Pressure Point: Bad Debt

The Middle-Class Tax Relief and Job Creation Act[1] instituted "bad debt" cuts as a means for paying for the program. Between 2012 and 2015, rural hospitals have absorbed a reduction in reimbursable bad debt, dropping from 100 percent to 65 percent.

This 35 percent decrease for what is often referred to as charity care, has been one of the key factors negatively impacting the financial performance of rural providers. This analysis into bad debt and its ramifications on the rural health safety net estimates the 10-year impact of these cuts using 2015 Cost Report data.

The community impact of bad debt cuts over a 10-year period:

- **$1.4 billion** in lost Medicare reimbursement among rural hospitals
- **62,000 jobs lost** in rural hospitals and communities
- **$7.3 billion** GDP loss

The impact has been most severe in states which have chosen not to expand Medicaid under the ACA. In states that have expanded Medicaid, many of the charity care services previously offered are now offered to citizens newly insured under the ACA. However, for rural providers in states that did *not* expand Medicaid, the same level of charity care continues to be provided but without the ability to seek reimbursement for uncompensated services.

Further exacerbating these cuts is the emergence of commercial bad debt. Unlike charity care, which typically involves uninsured patients, commercial bad debt is associated with insured patients unable to pay for medical services due to high deductible plans which can be as much as $5,000. Anecdotes gathered from rural hospitals indicate that many providers are finding it difficult to collect full payments in a timely manner, if at all.

Rural Pressure Point: CAH Reimbursement

The Balanced Budget Act (BBA) of 1997 authorized the creation of the Critical Access Hospital (CAH) with special conditions of participation and special reimbursements intended to maintain access to critical care in rural areas with low volumes of patients. Cost-based reimbursement created an annual settlement, whereby Medicare pays the hospital 101 percent of allowable costs filed on their cost report. This program has been helpful in maintaining rural access to care and as a counter to the unintended consequences associated with the development of the Prospective Payment System. The CAH system is largely viewed as a life raft for the fragile rural health safety net.

The impact of recommended CAH Reimbursement cuts over a 10-year period:

- **$1.2 billion** in lost Medicare reimbursement among CAHs
- **52,000 jobs lost** in CAH hospitals and communities
- **$6.1 billion** GDP loss

[1] Pub.L. 112–96, H.R. 3630, 126 Stat. 156, enacted February 22, 2012.

States primarily in the Midwest would suffer the greatest losses in Critical Access Hospital revenue and see the most job loss as a result of these reimbursement cuts. In large part, this is driven by the rural nature of these states and the large number of hospitals spread out across relatively agrarian counties (see Rural Relevance Chart Book, Chapter 2, Policy Impact).

Rural Pressure Point: PPS Coding Offset

Under the American Taxpayer Relief Act (ATRA),[1] Congress required CMS to recoup "excessive" payments from 2008-2013 under the prospective payment system (PPS). Additionally, the legislation authorized further coding offset for increases seen during this period. This cut was proposed by CMS and then withdrawn, but policymakers continue to include it as part of deficit reduction and cost containment policy.

As coding changes evolve, some higher fee services have been collapsed under one lower cost code based upon CMS evaluation of physician practices that offer similar services, often at lower cost. This reflects a pain point for rural hospitals treating numerous ambulatory conditions in their outpatient clinics. In rural communities, these hospital-based clinics may be the only places to receive such interventions, and yet may carry a higher cost burden given the nature of hospital overhead structure.

The community impact of a PPS Coding Offset over a 10-year period:

- **$359 million** in lost Medicare reimbursement among rural hospitals
- **16,000 jobs lost** in rural hospitals and communities
- **$1.8 billion** GDP loss

Individual states could see losses exceeding $20 million in hospital revenue (such as California) and over $100 million in GDP (such as North Carolina) (see Rural Relevance Chart Book, Chapter 2, Policy Impact).

Value-based Purchasing (VBP)

The smallest rural hospitals, typically CAHs, can't participate in the CMS Value Based Purchasing Program (VBP), also called Pay for Performance, which withholds a percentage (two percent) of Medicare inpatient payments and puts them into a pool for bonus (and penalty) payments. Hospitals that achieve a benchmark of value will see these monies remitted and may earn additional payments if they exceed the benchmark. Hospitals that do not meet the benchmark will forfeit these payments. In this way, CMS is providing incentives (and penalties) for hospitals to chase the value curve in defined areas of Quality, Outcomes, Patient Satisfaction and Efficiency.

The 2017 Rural Relevance Study models the CMS 2018 Value Based Purchasing (VBP) rules and applies these to the rural and CAHs to empirically evaluate how well the rural safety net functions. If the 2018 CMS VBP program were in effect today and applied to all rural hospitals, it would create an inflow of nearly $207 million to these providers.

Based on the current performance of rural healthcare, CAHs should welcome value-based purchasing incentives. If 2018 rules were currently in effect, CAHs could expect to earn $23 million in bonus payments nationally based on current performance.

[1] Pub.L. 112–240, H.R. 8, 126 Stat. 2313, enacted January 2, 2013.

- Using the 2018 rules, CAHs would receive $22.8 million in value-based reimbursements, preserving over 1,000 jobs and $124 million in GDP in 2018. There would be potential to secure another $52.3 million with performance increases, which would preserve an additional 2,000 jobs and $261 million in GDP.
- The average CAH is expected to realize $17,000 in bonus payments, with the opportunity to capture an additional $38,000 with performance increases.
- CAHs outperform their rural PPS peers. Rural PPS hospitals can expect to see an overall loss of nearly $21 million from their withholding amounts nationally.
- Nearly $270 million in bonus dollars would be available for the rural PPS hospitals with performance increases.

It is important to note that the current VBP program is *inpatient* focused and is not the best fit with small rural hospitals with low inpatient volumes as CAHs see an average of 74.4 percent of their patient volume as outpatients.[1] To address this, CMS has requested the development of a candidate rural-relevant VBP measure set by the National Quality Forum (NQF). This candidate measure set has been promulgated and awaits trial in the field. A key recommendation of the NQF is the inclusion of bonus payments for high performing rural safety net facilities, but not penalties such as those that exist for larger, less rural hospitals.

Policy Impact Chart Book: A detailed impact review of the policies highlighted in the study is available at iVantageINDEX.com. View the policy impact chart book here.

[1] Flex Monitoring Team Data Summary Report No. 16, October, 2014.

Disparities in Operating Margin Among Rural Providers: Medicaid Expansion

Medicaid expansion has proven to be a key driver of the implementation of provisions under the Affordable Care Act (ACA). The expanded coverage of individuals previously uninsured is one of the key provisions made optional in the U.S. Supreme Court case challenging the constitutionality of the ACA in National Federation of Independent Business (NFIB) v. Sebelius[1]. In the decision, the mandate to have insurance was deemed constitutional but not the "coercive" mechanism where states would either accept the expansion or risk losing existing Medicaid coverage. Thus, there has been uneven expansion of this key provision that has offered (or denied) millions of rural Americans health insurance coverage. Rural providers serving these populations have been directly impacted through enhanced payment resulting from increased insurance coverage for populations previously uninsured. This has been particularly noteworthy since bad debt cuts went into full effect (35 percent reduction) in 2015.

The 2017 Study finds that the expansion states have higher median rural hospital operating margins than non-expansion states. Additionally, the study notes variation by state and region explored next (see map on page 7).

Graves-Loebsack Save Rural Hospitals Act: An Alternative Model

Our exploration of operating margins led us to consider possible paths forward toward stability and sustainability. The Graves-Loebsack Save Rural Hospitals Act (HR 3225) includes provisions to both redress some of the policies/cuts explored in this study for the last six years as well as pave a way forward to codify into law new models for providing access to care in rural settings, borrowing from pilots that have been offered around the country. Under the proposed Save Rural Hospitals Act, Community Outpatient Hospital status preserves emergency and outpatient care for rural communities. The research shows that this conversion would financially benefit 97 percent of eligible hospitals currently operating at a loss.

This act, if passed, could preserve for communities the following over a 10-year period:

- **$5.4 billion** in lost Medicare reimbursement among rural hospitals
- **237,000 jobs lost** in rural hospitals and communities
- **$27.9 billion** GDP loss

This model is based upon the following elements of the Community Outpatient Hospital reimbursement structure. Note that this model is not inclusive of grant funding.

- 105 percent of reasonable costs reimbursed
- 100 percent of bad debt reimbursed
- Exemption from two-percent sequestration

[1] (567 U.S. ___ (2012), 183 L. Ed. 2d 450, 132 S. Ct. 2566

The 2017 Study finds that **rural hospital revenues may be impacted by a conversion to a new Outpatient/Emergency Hospital model with reductions in payment cuts and enhancements in reimbursements.** Please contact CCRH to model current performance under new models of reimbursement to better understand hospital performance under alternative models of service.

Rural Leaders Show the Way

The 2017 Top 100 Rural Providers

Across the spectrum of performance indicators, the Top 100 Rural and Community Hospitals and the Top 100 CAHs, as measured by the Hospital Strength INDEX (INDEX), are writing the blueprint for success as providers in rural America. Our research shows that these leaders share key attributes that dovetail with the vision articulated by the Triple Aim: better health for populations, better outcomes for patients and doing so at lower cost.[1]

Using the INDEX, characteristics of this year's top performing rural providers are compared to one another by the applicable peer group. By comparing the Top 100 cohorts of CAHs (see Rural Relevance Chart Book, Chapter 3, Value Leaders) and Rural and Community hospitals (see Rural Relevance Chart Book, Chapter 3, Value Leaders) to their respective counterparts across the U.S., the analysis highlights the areas of strength of top performers while at the same time establishing benchmarks for all other providers.

- Top performing CAHs boast a median overall percentile rank of 95.0 versus the all-CAH median of 51.6 on the Hospital Strength INDEX.
- The median Top 100 Rural and Community facility performs in the 94.4 percentile compared to a national median of 46.5.
- Top 100 CAHs capture more Medicare IP business than 84.3 percent of all other rural hospitals and greater Medicare OP market share than 91.8 percent of all other rural hospitals within a defined PSA.
- When looking at Outcomes, top CAHs excel at keeping readmission and mortality rates low.
- Top rural and community hospitals produce consistently better outcomes at much lower average case-weight and wage-rate adjusted Medicare IP and OP costs.
- Finally, this cohort analysis reveals significant distinction in Financial Stability (measured by Capital Efficiency [Net Income/Total Revenue]), whereas Top 100 CAHs score higher than two-thirds of all other providers in the study.

[1] Institute for Healthcare Improvement, 2017.

While top performing CAHs and rural and community hospitals perform significantly better compared to their peers, there are differences in areas of relative strength when compared against one another (see Rural Relevance Chart Book, Chapter 3, Value Leaders). When looking at value, for example, Top 100 CAHs show stronger performance as compared to Top 100 Rural and Community hospitals in the Medicare Process of Care measures that comprise the Quality Pillar, as well as the Patient Satisfaction Pillar comprised of HCAHPS scores.

Across the nation, there is a wide range of performance among rural providers. The INDEX provides an analysis of the value of the safety net performance nationally and cascades this analysis to states, regions, etc. Numerous states subscribe to the INDEX to offer a hospital-by-hospital analysis of performance and to direct resources for performance improvement. The following section compares performance characteristics of the rural hospitals across the nation to non-rural providers.

Where does your facility stand in 2017? Contact CCRH to assess individual hospital performance and learn what it takes to become a Top 100 Rural Hospital.

Rural Provider Performance Compared with Non-Rural Provider Performance

Quality, Outcomes and Patient Satisfaction

- **Quality**: Rural providers score better in emergency department (ED) Arrival to Admission Times for Admitted ED Patients (rural 220 min to non-rural 311 min), ED Arrival to Departure Times for Discharged ED patients (rural 117 min to non-rural 161), Median time from ED arrival to provider contact (rural 21 min to non-rural 30 min), and Median Time to Pain Management (rural 49 min to non-rural 56 min).
- **Outcomes**: Rural providers perform better than their non-rural counterparts for Heart Failure (HF) Readmission (rural 21.8 to non-rural 22), pneumonia (PN) Readmission (rural 16.9 to non-rural 17.3) and hospital-wide readmission (rural 15.5 to non-rural 15.7).
- **Patient Satisfaction:** Rural providers outperform non-rural in overall ranking – receiving a 9 out of 10, as well as in eight individual categories including nurse communication, doctor communication, pain control, medication explanation and discharge instructions.

Costs and Charges

Costs and charges are important to consider in rural health. Even though they don't reflect the ultimate consumer price, they do influence the final payment or settlement. Costs are important because they set the floor below which hospitals will lose money. Rural hospital costs are also important because they establish the basis for a Medicare settlement for cost-based reimbursements to help keep low volume

rural safety net providers "whole." Charges, on the other hand, are set by the hospital and may serve as the basis for negotiated payments by commercial insurance companies that reimburse hospitals at a premium compared with Medicare in 96 percent of inpatient services[1]. Charges may vary widely by hospital for the same services and final payments show wide variation for the same services observed.[2] However, as noted earlier, rural hospitals receive most payments from government payors that pay on a fee schedule.

Rural providers are concerned that their cost and charge structure will become misaligned with the wider market in such a way that ultimately undermines the attractiveness of the safety net. The 2017 study examined costs and charges in inpatient areas (based upon Diagnostic Resource Group volumes (DRGs) and outpatient service areas) with the highest volumes (see Rural Relevance Chart Book, Chapter 3, Value Leaders).

- Rural hospitals charge far less than their non-rural counterparts on a case-mix and wage adjusted basis. This difference is especially apparent in the inpatient setting, but also holds true among outpatients. Rural hospital charges are particularly low for common inpatient stays such as pneumonia, kidney and urinary tract infection, heart failure and COPD when wage and case-mix adjusted.
- Non-rural hospitals outperform rural facilities with respect to outpatient Medicare costs, sustaining lower costs across many common procedures when case-mix and wage adjusted. However, rural hospitals perform just as well with respect to inpatient costs among Medicare patients.

Value Leaders Chart Book: Detailed analysis of top performing rural hospitals, as well as a review of rural provider performance versus non-rural providers is available at iVantageINDEX.com. View the value leaders chart book here.

[1] National Comparisons of Commercial and Medicare Fee-For-Service Payments to Hospitals, 2016.
[2] The Dramatic Difference: What a Hospital Charges vs. What Medicare Pays. Kaiser Family News, 2013.

Conclusion

In summary, the rural health safety net serves a population that is older, poorer and sicker with less access to care than their non-rural counterparts. This population has a higher proportional demand for healthcare given baseline health disparities. The rural health safety net is anchored by rural hospitals that offer critical access to quality care. Through federal and state polices and rural-relevant reimbursements, this safety net has been designed to provide access to populations which are geographically dispersed and often underserved. Yet this safety net continues to be threatened by potential policy changes at both state and federal levels.

Rural healthcare providers serve to support not only the health of their population, but also the health of the local economy and, by extension, the communities served. The shift from local rural access to non-rural centers of care may not offer savings, but shifts the spend from rural to non-rural, often with negative consequences in terms of access, care and cost. As cost savings initiatives are considered, care must be taken so that the industry doesn't *"trip over a dollar to save a dime"* as is typically the case when considering the overall cost of supporting local access to care for rural populations.

While there is no question that non-rural providers provide more sophisticated interventions for the sickest patients, the study confirms that rural providers offer quality care with good outcomes and high levels of patient satisfaction at the median as compared to more non-rural counterparts for the care they offer.

Preserving access to all types of care, especially inpatient care, may be out of the reach of the smallest providers. But rural providers have a critical role to play in developing alternative care models for a geographically dispersed, heterogeneous populations, leading the way toward answering the key question around the care models of the future for rural America.

Against this context, rural providers should act now to prepare for changes ahead. Developing a comprehensive understanding of an organization's current performance, position and exposure is critical, as is aligning leadership around the most likely scenarios ahead. As has been the case for the last six years, the Rural Relevance Study offers a snapshot into the state of rural healthcare, the value the safety net provides and the challenges and opportunities for the future.

About the Hospital Strength INDEX®

The Hospital Strength INDEX is rural healthcare's most comprehensive and objective assessment of rural providers. By assessing performance across more than 50 individual indicators and eight pillars of performance, INDEX brings a rural-relevant perspective to healthcare leaders making strategic and operational decisions. The INDEX is the foundation for many of rural healthcare's most prominent awards (e.g. Top 100 Critical Access Hospitals, NOSORH Performance Excellence Awards) and is used by organizations such as the National Rural Health Association in support of its advocacy and legislative initiatives.

Since its inception, the INDEX has helped more than 750 rural and Critical Access Hospitals integrate sophisticated analytics for benchmarking performance, and has also been used by more than 25 state agencies, state hospital associations, federal grant programs and both the National Rural Health Association (NRHA) and the National Organization of State Offices of Rural Health (NOSORH). INDEX analytics have also informed healthcare industry policy, research and thought leadership.

Study Note

The total number of rural hospitals included in the analysis is 2,157, which includes hospitals designated as rural by the Office of Rural Health Policy (ORHP), a division of the Health Resources & Services Administration (HRSA) and excludes hospitals with more than 200 beds.

The methodology behind INDEX uses publicly available hospital level data to (a) identify the variables that statistically contribute to the measures of cost, quality, outcomes and patient perspective and (b) score each hospital on each measure based on the weighting of each variable as determined by a principal components analysis. The use of publicly available hospital data comes with the inherent problem of missing data for some hospitals. To address this issues, INDEX uses a multiple imputation approach to provide estimates of missing variables based on available data.

All available data are included. Statistical sampling and data projection methodologies are employed only when necessary. Each INDEX release is based on the most recently available data for each indicator source. All information included in this release (version 7.0) represents the most recently available data as of December, 2016.

INDEX is based on a composite measure of eight pillars:

- Inpatient Market Share
- Quality
- Patient Perspective
- Charges
- Outpatient Market Share
- Outcomes
- Cost
- Financial Stability

The methodology is reviewed and revised as necessary each year to ensure it provides a current and relevant analysis of rural hospital performance. The current methodology is available online at www.iVantageINDEX.com.

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CHARTIS CENTER FOR RURAL HEALTH

The Chartis Center for Rural Health (CCRH) builds upon the commitment of The Chartis Group and iVantage Health Analytics to deliver expertise, performance management solutions, advisory services and research to the system-supported rural facilities, community hospitals, and Critical Access Hospitals which provide care to more than 60 million Americans.

Pairing iVantage's extensive knowledge of rural healthcare, research and solution portfolio with the healthcare expertise and resources of The Chartis Group, CCRH creates an unparalleled value proposition for rural health leaders and those advocating on their behalf. The Chartis Center for Rural Health provides insight, perspective, analysis and solutions to this important healthcare segment in order to address the biggest challenges and drive performance improvement.

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Reducing Potentially Excess Deaths from the Five Leading Causes of Death in the Rural United States

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View suggested citation

Background

In 2014, the all-cause age-adjusted death rate in the United States reached a historic low of 724.6 per 100,000 population (*1*). However, mortality in rural (nonmetropolitan) areas of the United States has decreased at a much slower pace, resulting in a widening gap between rural mortality rates (830.5) and urban mortality rates (704.3) (*1*). During 1999–2014, annual age-adjusted death rates for the five leading causes of death in the United States (heart disease, cancer, unintentional injury, chronic lower respiratory disease (CLRD), and stroke) were higher in rural areas than in urban (metropolitan) areas (Figure 1). In most public health regions (Figure 2), the proportion of deaths among persons aged <80 years (U.S. average life expectancy) (*2*) from the five leading causes that were potentially excess deaths was higher in rural areas compared with urban areas (Figure 3). Several factors probably influence the rural-urban gap in potentially excess deaths from the five leading causes, many of which are associated with sociodemographic differences between rural and urban areas. Residents of rural areas in the United States tend to be older, poorer, and sicker than their urban counterparts (*3*). A higher proportion of the rural U.S. population reports limited

physical activity because of chronic conditions than urban populations (*4*). Moreover, social circumstances and behaviors have an impact on mortality and potentially contribute to approximately half of the determining causes of potentially excess deaths (*5*).

Potentially excess deaths (also described as potentially preventable deaths) are defined as deaths among persons aged <80 years in excess of the number that would be expected if the death rates for each cause were equivalent across all states to those that occurred among the three states with the lowest rates (*6,7*). Although not all potentially excess deaths can be prevented, many might represent deaths that could be prevented through improved public health programs that support healthier behaviors and neighborhoods and better access to health care services.

Reducing Potentially Excess Deaths in Rural Areas of the United States

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In 2014, approximately 62% of all 1,622,304 deaths in the United States were related to the five leading causes of death (6). During 2014, the number of potentially excess deaths from the five leading causes in rural areas was higher than those in urban areas (*8*). Targeted, needs-based prevention efforts, combined with improved access to treatment for chronic conditions, might reduce the rural-urban gap in age-adjusted death rates and potentially excess deaths from the five leading causes of death.

Heart Disease, Stroke, and Chronic Lower Respiratory Disease

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Heart disease, stroke, and CLRD share several substantial co-morbidities from individual behavioral and social risk factors (*9–12*). The percentage of potentially excess deaths from these three causes is higher in rural than urban areas in all 10 regions (*8*). In addition, potentially excess deaths among regions vary substantially. For example, the percentages of excess deaths in urban areas in regions 3, 4, 5, 6 and 7 related to stroke are higher than even the rural area percentages in regions 1, 2, 8, 9, and 10. For these three causes of potentially excess deaths, the highest urban percent in one or more regions is higher than the lowest rural percentages in three or more regions. Stroke is the most prominent example: urban excess deaths in regions 4 (South East) and 6 (New Mexico, Texas, Oklahoma, Arkansas, and Louisiana) far outpace rural excess deaths in regions 1, 2, 5, 7, 8, 9 and 10. In region 5 (Great Lakes), rural-urban differences in potentially excess deaths nearly disappeared for heart disease and stroke. Additional research is needed to understand the causes of these differences and what can be learned from both the broad regional differences across the United States and the near elimination of rural-urban differences in the Great Lakes region.

Tobacco use increases the risk for developing and dying from heart disease, stroke, and CLRD. Cigarette smoking is the leading cause of preventable disease and death in the United States (*13*) and is the most substantive risk factor for CLRD (*10*). Nationally, the prevalence of cigarette

smoking among adults living in rural counties is higher than in urban counties, and smoking rates differ markedly by region, making tobacco use a likely leading cause of differential mortality between urban and rural areas (*4*). Understanding where tobacco use in rural areas is higher than urban areas can help prioritize resources to reduce tobacco use and secondhand smoke exposure and begin to address the increasing numbers of CLRD-related deaths in rural areas.

Heart disease and stroke mortality rates are decreasing in both rural and urban areas. However, this improvement in mortality trends is plateauing and the rate of decline for heart disease in rural areas is slowing relative to urban areas, thus increasing the differential rural-urban gap in mortality rates (*8*). In 22 states, including rural states such as Alaska, Idaho, Kentucky, Montana, Vermont and West Virginia, the number of deaths attributed to heart disease declined below the number of cancer deaths for the first time (*8*). For stroke, the difference in the number of deaths in rural and urban areas remained constant, with substantive declines in both rural and urban areas (*8*). In 2013, stroke declined from the third to the fifth leading cause of death in nonmetropolitan areas (*14*). Lack of physical activity, poor nutrition (especially diets high in calories, sodium, added sugars, and saturated fat), and associated obesity are major risk factors for hypertension and diabetes (*15*). These risk factors and conditions contribute substantially to heart disease and stroke death rates in the United States and are more prevalent in rural areas than urban areas. Obesity has been linked to a variety of serious chronic illnesses, including diabetes, heart disease, cancer, and arthritis (*16–18*). From 1960 to 2010, the proportion of adults in the United States who were overweight or obese increased from 40.5% to 66.1% (*19*). Self-reported obesity was higher in rural areas than urban areas and increased with increasing levels of rurality (*4*). Regular physical activity and improved physical fitness offer numerous health benefits, including reduced risk for cardiovascular disease, diabetes, obesity, some cancers, and musculoskeletal conditions (*20*). Despite evidence of modest increases in the prevalence of physical activity and improved nutrition, the prevalence rates of hypertension and diabetes have not been improving over time (*21,22*). However, a greater percentage of adults with hypertension are controlling their blood pressure (*23*), and since 2006 there has been a sustained decline in the incidence of diabetes and a plateauing in the prevalence of diabetes nationally (*24*).

Barriers to health care access result in unmet health care needs that include, but are not limited to, a lack of preventive and screening services, treatment of illnesses (*25*) and timely urgent and emergency services (*26*). Residents of rural areas experience many of these barriers. Specifically, rural counties in the United States have a higher uninsured rate (*27*); experience health care workforce shortages (approximately only 11 percent of all physicians choose to practice in rural settings) (*28*); often lack subspecialty care (e.g., oncology), critical care units, or emergency facilities (*29*); have limited transportation options; and experience longer time to services caused by distance (26). Differential access to quality health care (*25*), including timely access, likely contributes to

rural-urban gaps in mortality rates and potentially excess deaths. For example, persons with CLRD and unmet health care needs in rural areas can experience serious life-threatening respiratory episodes, and the lack of timely access to emergency care could affect survival. In contrast, the parallel mortality trends for stroke might be explained by the success of complementary programs that improve the quality of stroke care. These programs (CDC's *Paul Coverdell National Acute Stroke Program*, the American Heart Association/American Stroke Association's *Get with the Guidelines* program, and The Joint Commission's Certification for Primary Stroke Centers program) organize systems that coordinate acute stroke care across both urban and rural hospitals (*30*). However, comparable programs to improve cardiac care have not been implemented in rural areas, which might account for divergent trend in myocardial infarction mortality rates.

Cancer

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During 2003–2012, the overall cancer-related age-adjusted death rate decreased by 1.5% per year (*31*); however, rates declined less in rural than urban areas (*8*). Age-adjusted death rates from cancer have mirrored decreases in the prevalence of risk factors such as tobacco use, which is a shared risk factor with heart disease, stroke, and CLRD (*10–12*), and increases in cancer screening, vaccinations, and improvements in treatment (*31*). Differences in these death rates might reflect higher prevalence of tobacco-use and obesity in rural areas (*4*) and lack of access to cancer screening services, follow-up to abnormal tests, quality care for cancer patients, and cancer survival care (*32*).

To address the rural-urban gap in cancer-related potentially excess deaths, comprehensive approaches that encompass the cancer continuum (e.g., prevention, early detection, treatment, and survivorship) are needed at the local and state level to reduce risks associated with potentially excess deaths from cancer in rural areas (*33*). Comprehensive cancer-control programs are funded by CDC in 50 states, the District of Columbia, seven tribes and tribal organizations, and seven U.S. territories and Pacific Island jurisdictions (https://www.cdc.gov/cancer/ncccp/about.htm (https://www.cdc.gov/cancer/ncccp/about.htm)). These programs build coalitions that develop and implement strategic plans for cancer prevention and reduce morbidity and mortality for persons affected by cancer.

CDC also supports cancer screening programs that address health disparities among adults who are uninsured or underinsured (*34,35*), which is a common characteristic among rural populations (*32*). Historically, funding for the National Breast and Cervical Cancer Early Detection Program and the Colorectal Cancer Control Program has focused on direct screening services. Since 2012, emphasis has shifted to population-based approaches, such as partnering with health systems to implement evidence-based interventions to increase population-level screening (*36*), including provider reminders for persons who are due for cancer screening (*37*).

As differences in cancer-related death rates are addressed at the local and state level, opportunities are available to address them at the federal level. The Cancer Moonshot is focused on accelerating the understanding of cancer and its prevention, early detection, treatment, and cure, including improving access and care (*38*). Although some components of this federal initiative target the genomic level, when combined with population-based approaches, the rural-urban gap in cancer-related deaths rates might be reduced.

Unintentional Injury

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During 2008–2010, the annual age-adjusted death rates for unintentional injury were highest in rural counties (*8*). During 1999–2014, the age-adjusted death rates for unintentional injuries were approximately 50% higher in rural areas than urban areas (Figure 1). Several factors explain the wide gap in rural-urban death rates from unintentional injuries. First, unintentional injury burden is higher in rural areas because of severe trauma associated with high speed motor vehicle traffic-related deaths (*4*). Second, rates of opioid analgesic misuse and overdose death are highest among poor and rural populations (*39*). Third, behavioral factors (e.g., alcohol impaired driving, seatbelt use, and opioid prescribing) contribute to higher injury rates in rural areas (*40–42*). Fourth, access to treatment for trauma and drug poisoning is often delayed when the injury occurs in rural areas. For life-threatening injury, higher survival is associated with rapid emergency treatment (*43,44*). Because of the geographic distance involved, emergency medical service (EMS) providers who operate ambulances take longer to reach injured or poisoned patients in rural areas. Moreover, ambulatory transport to the optimal treatment facility also can take longer because of increased distance to the treatment facility. Most life threatening trauma is best treated in advanced trauma centers, which are usually located in urban areas; care at these centers has been associated with 25% lower mortality (*45*). Trauma centers have advanced equipment and specialized staff available 24 hours, 7 days a week. Such care also includes access to advanced neurosurgical care, which is important because approximately one third of all injury-related deaths involve a traumatic brain injury. Regulatory restrictions and EMS capability and certification to treat drug overdose cases with naloxone at the scene of overdose events also might be a factor in higher opioid poisoning-related deaths in rural areas.

Interventions to address the disproportionate unintentional injury death rates in rural areas include increased adherence to guidelines for triaging ambulatory transport destinations (*46*), changing state rules to expand the types of EMS providers that can administer naloxone to reverse a drug overdose (*47*), and enforcement of motor vehicle seatbelt and alcohol laws to reduce motor vehicle crashes (*48*). Educating rural opioid prescribers on the opioid guideline (*49*) and better access to opioid agonist medication-assisted treatment programs probably would benefit rural communities

with high opioid use disorder rates (*50*). Quicker access to definitive trauma and opioid dependency treatment and additional interventions are needed to reduce unintentional injury deaths in rural areas.

Conclusion

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In the United States, there is a rural-urban gap in age-adjusted death rates and potentially excess deaths from the five leading causes of death. Rural communities experience higher age-adjusted death rates and a higher number of potentially excess deaths from the five leading causes compared with urban areas. Higher death rates and potentially excess deaths are often associated with various interconnected societal, geographic, behavioral, and structural factors. Historic trends indicate that focusing on access to health care in rural areas of the United States alone is not sufficient to adequately address complex health outcomes, including mortality among rural populations (*3*). Consistent with the recommendations and best practices described in this report, approaches to address the nonuniform achievements in rural areas must focus on strengthening the health care delivery system while improving and increasing the integration of primary, specialty, and substance abuse services (*3*). Identifying structural and societal modifiable factors contributing to the gap between rural and urban mortality outcomes from the five leading causes of death is challenging. Additional analysis can yield results that inform the strategic alignment of resources with condition-specific needs. To reverse the widening gap in age-adjusted death rates from unintentional injuries between rural and urban areas, special attention should be given to designing, implementing, and monitoring locally informed initiatives in rural communities for the effective prevention and treatment of opioid misuse, including treatment of opioid overdose. Needs-based allocation of resources can substantially impact rural health. Although rural communities are at higher risk for death from the five leading causes of death, funding to address risk factors is allocated on a population basis (*3*), often resulting in underfunded rural programs. An increased emphasis on need and epidemiologic burden of disease as major factors in targeting future allocation of public health and prevention funding might contribute, among other factors, to bridging the mortality gap from the five leading causes of death between rural and urban areas in the United States.

Acknowledgments

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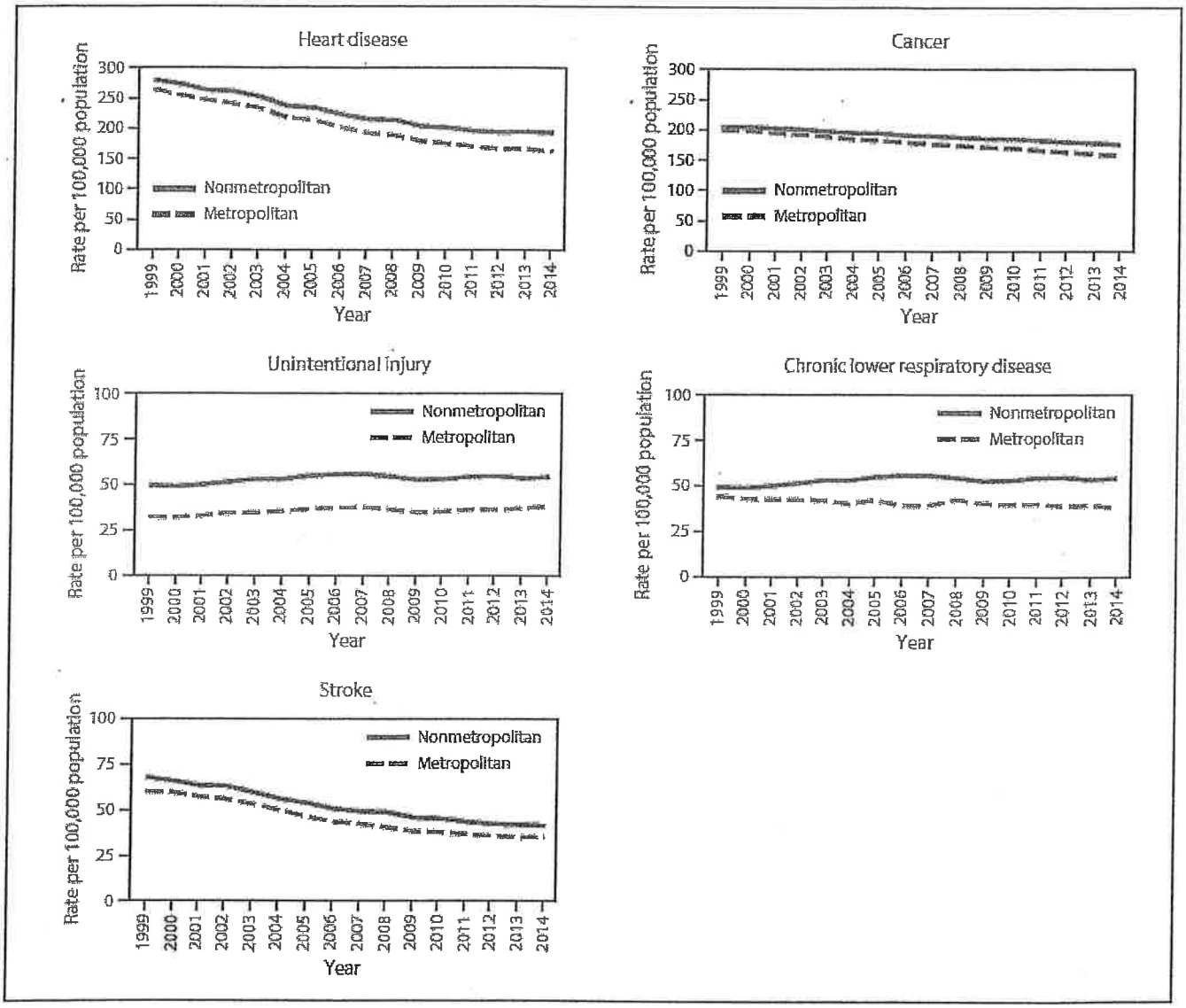
^ Top

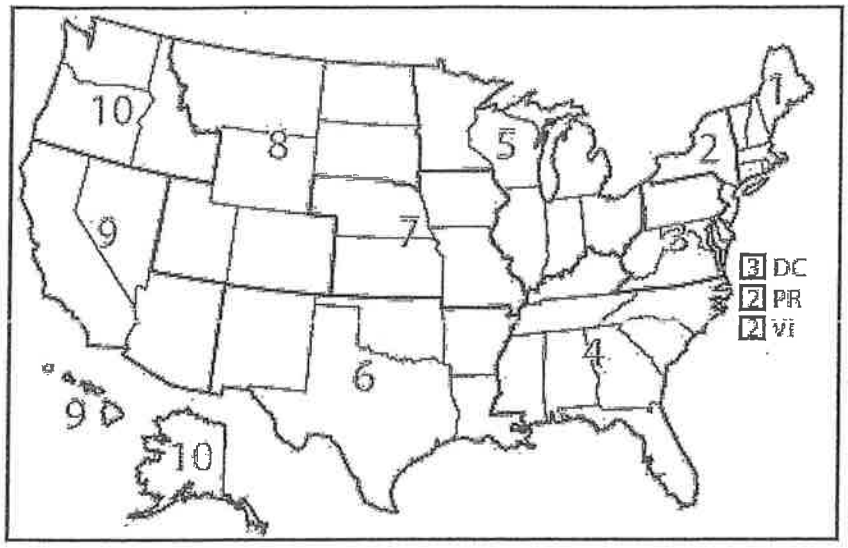
FIGURE 1. Age-adjusted death rates among persons of all ages for five leading causes of death in nonmetropolitan and metropolitan areas,* by year — National Vital Statistics System, United States, 1999–2014



Source: Moy E, García MG, Bastian B, et al. Leading causes of death in nonmetropolitan and metropolitan areas—United States, 1999–2014. MMWR Surveill Summ 2017;66(No. SS-1).

* Nonmetropolitan and metropolitan areas were identified using the Office of Management and Budget's 2013 county-based classification scheme. (**Source:** Office of Management and Budget, White House. Revised delineations of metropolitan statistical areas, micropolitan statistical areas, and combined statistical areas, and guidance on uses of the delineations of these areas. Washington, DC: Office of Management and Budget; 2013.
https://www.whitehouse.gov/sites/default/files/omb/bulletins/2013/b13-01.pdf
(https://www.whitehouse.gov/sites/default/files/omb/bulletins/2013/b13-01.pdf))

FIGURE 2. U.S. Department of Health and Human Services public health regions* Top



Source: Moy E, García MG, Bastian B, et al. Leading causes of death in nonmetropolitan and metropolitan areas—United States, 1999–2014. MMWR Surveill Summ 2017;66(No. SS-1).

* *1* = Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont; *2* = New Jersey, New York, Puerto Rico, and the U.S. Virgin Islands (Mortality data for residents of U.S. territories were excluded.); *3* = Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, and West Virginia; *4* = Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee; *5* = Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin; *6* = Arkansas, Louisiana, New Mexico, Oklahoma, and Texas; *7* = Iowa, Kansas, Missouri, and Nebraska; *8* = Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming; *9* = Arizona, California, Hawaii, and Nevada; *10* = Alaska, Idaho, Oregon, and Washington.

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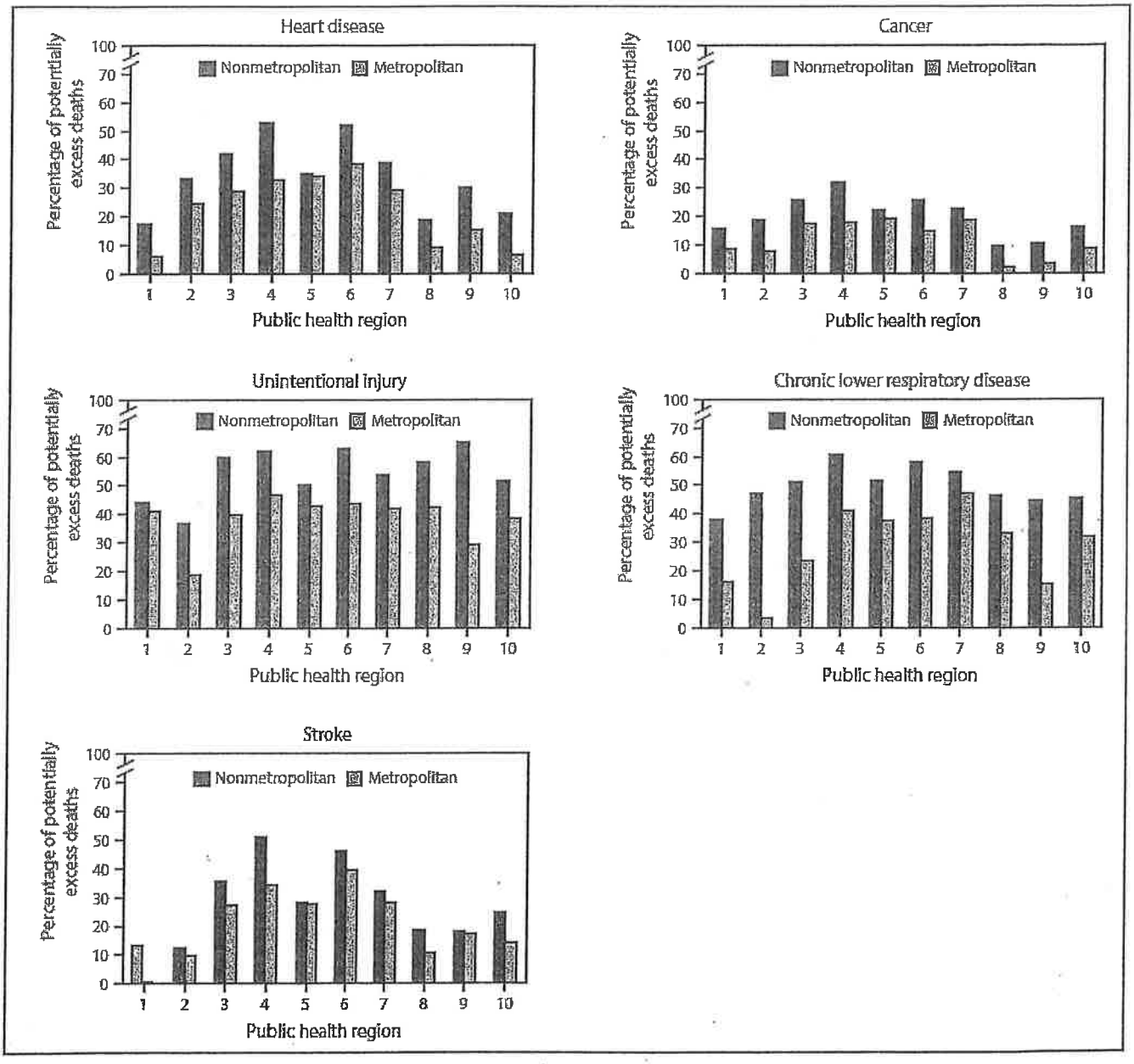
FIGURE 3. Percentage of potentially excess deaths* among persons aged <80 years for five leading causes of death in nonmetropolitan and metropolitan areas,† by year and public health region§ — National Vital Statistics System, United States, 2014



Source: Moy E, García MG, Bastian B, et al. Leading causes of death in nonmetropolitan and metropolitan areas—United States, 1999–2014. MMWR Surveill Summ 2017;66(No. SS-1).

* For each age group and cause, the death rates of the three states with the lowest rates during 2008–2010 (benchmark states) were averaged to produce benchmark rates. Potentially excess deaths were defined as deaths among persons aged <80 years in excess of the number that would be expected if the age group–specific death rates of the benchmark states occurred across all states.

† Nonmetropolitan and metropolitan areas were identified using the Office of Management and Budget's 2013 county-based classification scheme. (Source: Office of Management and Budget, White House. Revised delineations of metropolitan statistical areas, micropolitan statistical areas, and combined statistical areas, and guidance on uses of the delineations of these areas. Washington, DC: Office of Management and Budget; 2013. https://www.whitehouse.gov/sites/default/files/omb/bulletins/2013/b13-01.pdf (https://www.whitehouse.gov/sites/default/files/omb/bulletins/2013/b13-01.pdf)).

§ *1* = Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont; *2* = New Jersey and New York; *3* = Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, and West Virginia; *4* = Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee; *5* = Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin; *6* = Arkansas, Louisiana, New Mexico, Oklahoma, and Texas; *7* = Iowa, Kansas, Missouri, and Nebraska; *8* = Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming; *9* = Arizona, California, Hawaii, and Nevada; *10* = Alaska, Idaho, Oregon, and Washington.

^ Top

Suggested citation for this article: Garcia MC, Faul M, Massetti G, et al. Reducing Potentially Excess Deaths from the. MMWR Surveill Summ 2017;66(No. SS-2):1–7. DOI: http://dx.doi.org/10.15585/mmwr.ss6602a1 (http://dx.doi.org/10.15585/mmwr.ss6602a1) .

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How do I view different file formats (PDF, DOC, PPT, MPEG) on this site? (https://www.cdc.gov/Other/plugins/)

(https://www.cdc.gov/Other/plugins/#pdf)

Page last reviewed: January 12, 2017

Page last updated: January 12, 2017

Content source: Centers for Disease Control and Prevention (//www.cdc.gov/)

Department of Health & Human Services
Centers for Medicare & Medicaid Services
61 Forsyth St., Suite. 4T20
Atlanta, Georgia 30303-8909

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

June 14, 2017

Stephanie Boynton, CEO
Erlanger Bledsoe Hospital
71 Wheelertown Avenue
Pikeville, TN 37367

Re: Critical Access Hospital (CAH) Relocation Preliminary Determination

Dear Mrs. Boynton:

Thank you for providing us with the information regarding the proposed relocation of Erlanger Bledsoe Hospital. You provided documentation of continuing to meet all rural location and necessary provider requirements at 42 CFR 485.610, as well as documentation attesting to compliance with the 75% requirement at 42 CFR 485.610(d)(1). Based on our preliminary evaluation, Erlanger Bledsoe Hospital will meet all regulatory requirements regarding relocation of a Necessary Provider CAH when it relocates to the new address.

Please be aware that this is a preliminary evaluation only and the final determination cannot occur until after the CAH relocates and submits evidence that it continues to meet all requirements. After the relocation is complete, Erlanger Bledsoe Hospital must attest that it remains essentially the same provider serving the same community at the new location (per 42 CFR 485.610(d)(1)), and whether the information provided with the earlier attestation remains the same.

If you have any further questions, please do not hesitate to contact Jackie Whitlock at (404) 562-7437 or Jacqueline.whitlock@cms.hhs.gov.

Sincerely,

Jackie Whitlock for

Sandra M. Pace
Associate Consortium Administrator
Division of Survey & Certification

erlanger BLEDSOE

February 24, 2017

Ms. Sandra Pace
Associate Regional Administrator
Division of Survey and Certification Operations
Center of Medicare and Medicaid Services
63 Forsyth Street, SW, Suite 4T20
Atlanta, GA 30303-8909

RE: Erlanger Bledsoe Hospital Relocation
Request to Confirm CAH Designation

Dear Ms. Pace,

Erlanger Bledsoe Hospital, formerly Bledsoe County General Hospital, owned by Chattanooga Hamilton County Hospital Authority is a "necessary provider/critical access hospital" located in Pikeville, Bledsoe County, Tennessee (see attached documentation regarding our necessary provider designation). Erlanger Bledsoe Hospital wishes to advise you of its intent to replace and relocate its hospital facility from 71 Wheelertown Avenue, Pikeville, TN, Bledsoe County, to 17399 Rankin Avenue in Dunlap, TN, Sequatchie County. The new location is 20 miles from the current facility. The current hospital, originally a Hill Burton facility, is 45 years old and in need of replacement.

In the new location, Erlanger Bledsoe meets the criteria for maintaining the "necessary provider designation", as follows:

Population Served:
We will serve 75% of the population currently served. In the past year, we have served patients primarily in the following zip codes:
37327 Dunlap TN
37338 Graysville TN
37339 Gruetli TN
37347 Jasper TN
37365 Palmer TN
37367 Pikeville TN
37377 Signal Mtn. TN
37379 Soddy Daisy, TN
37397 Whitwell, TN

We anticipate 75% of our patients will continue to be located in these service areas, thus meeting the "75 of the same population served."

Services:
Erlanger Bledsoe will provide the same services that we currently offer, as well as, some additional services including surgery; therefore we will meet the "75% of same services offered criteria."

Employees:
Erlanger Bledsoe anticipates there will be an increase in the number of employees. All current employees will be offered employment at the new location; therefore we will meet the "75% of the same employee criteria. The new location is 20 miles from the current facility."

Rural Definition:
The proposed location will meet the rural area definition as defined by the State of Tennessee. Please see attached documentation.

Also, Erlanger Bledsoe Hospital currently operates a provider based emergency department located in Dunlap, TN, Sequatchie County. This provider based emergency department will be relocated to 553 US 127 Bypass, Pikeville, TN, Bledsoe County. The proposed location for the provider based emergency department is approximately 28 miles from Cumberland Medical Center via a two lane road, Highway 127S/ US-127S /TN-28. Rhea Medical is located approximately 22 miles via a two lane road, Dayton Mountain Highway, TN-30 (see attached map incorporating the geography and roadways referenced). The proposed location for the provider based emergency department meets the rural definition as defined by the State of Tennessee.

It is anticipated that the relocation and replacement of the facilities will be implemented and completed within 24-36 months, after all approvals are received.

We would appreciate your confirmation that our proposed relocation will not impact our current critical access designation/necessary provider status for both locations.

I am happy to answer any questions you may have about this submission either via the telephone or in person, as you review our submission. Please feel free to call me at 423-447-5350.

Thank you for your review of this matter.

Sincerely,

Stephanie Boynton

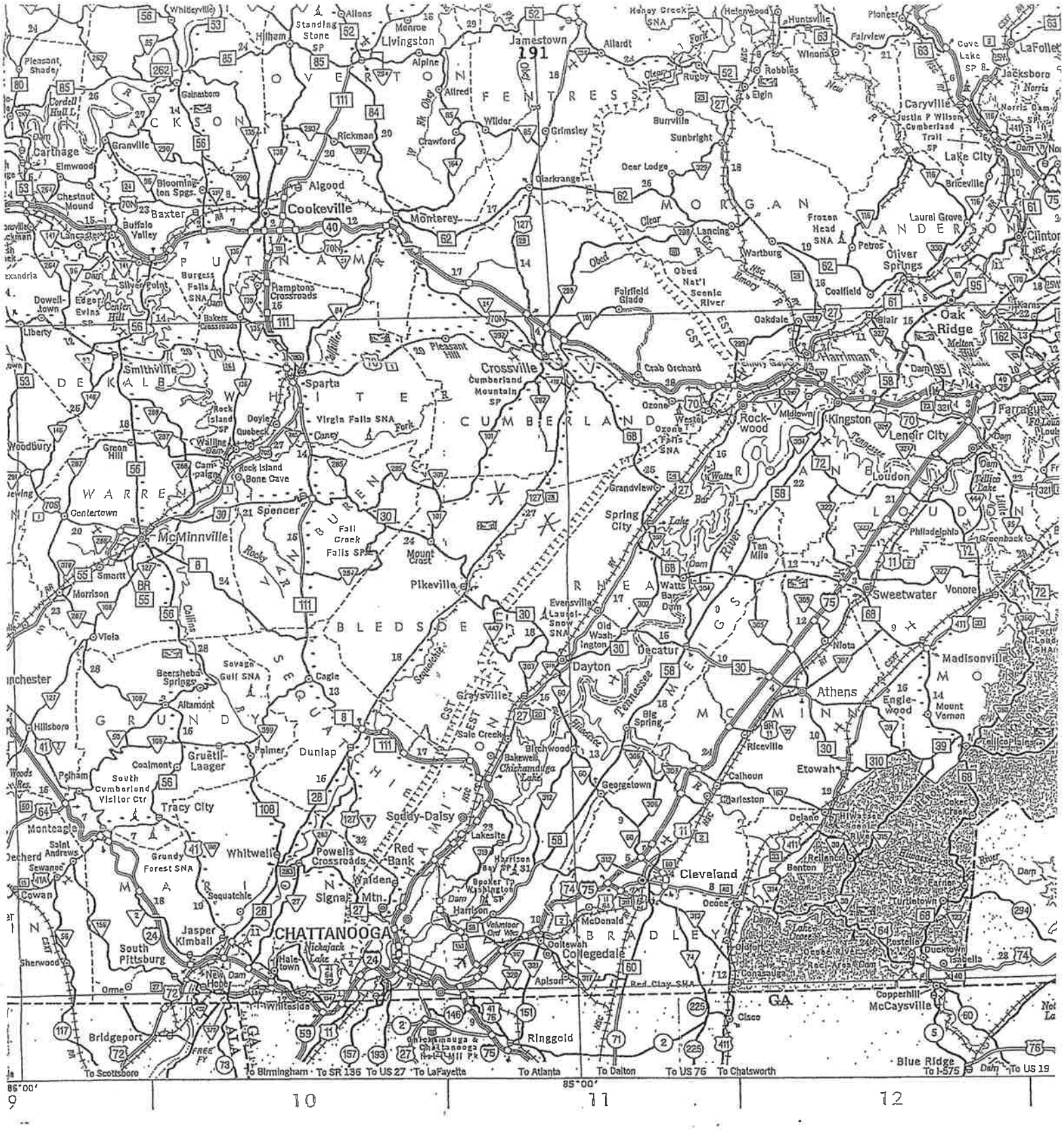
Stephanie Boynton
CEO Erlanger Bledsoe and SVED

CC: Joe Winick
Rob Brooks
Alana Sullivan

Steven Johnson
Britt Tabor
Bill Jolley, THA

Attachments:

Official Tennessee Transportation Map
Necessary Provider Documentation, Department of Health and Human Services
Rural Definition from State of Tennessee
Mapquest documentation regarding site locations
License



THE MILEAGE CHART

en cities is shown at the zontal and vertical columns for resent the approximate shortest es via interstate, U.S. or state For example: Athens to es.

nty with respect to the accuracy leage and other features shown or comments about the Official

FREE MAP

Order a complimentary copy of this map online at http://www.tennessee.gov/tdot/maporder/maporder.htm. One map per individual may be mailed. Organizations can order additional copies. The map is for free distribution only and cannot be sold.

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DEPARTMENT OF HEALTH & HUMAN SERVICES

Region IV
Health Care Financing
Administration

Bill Blanton

Refer to: tnrhp.cah

Atlanta Federal Center
61 Forsyth Street, SW, Suite 4T20
Atlanta, Georgia 30303-8909

March 10, 1999

Fredia S. Wadley, M.D.
Commissioner
Tennessee Department of Health
Cordell Hull Building, Third Floor
425 5th Avenue, North
Nashville, TN 37247

Dear Dr. Wadley:

This is to advise you that the Health Care Financing Administration (HCFA) has approved the Tennessee Rural Health Care Plan to participate in the Medicare Rural Health Flexibility Program. We appreciate the efforts of the Office of Rural Health and Health Access and the Tennessee Hospital Association in developing the plan. Please note that no provider agreement may be issued to a critical access hospital until all network agreement signatures have been obtained.

Should there be any questions concerning this matter, please contact Bill Blanton at (404) 562-7433.

Sincerely,

Eugene A. Grasser
Associate Regional Administrator
Division of Medicaid and State Operations

DEPARTMENT OF HEALTH & HUMAN SERVICES

Region IV
Health Care Financing
Administration

Bill Blanton

Refer to: tnrhp.cah

Atlanta Federal Center
61 Forsyth Street, SW, Suite 4T20
Atlanta, Georgia 30303-8909

COMMISSIONER
Received
MAR 15 1999
DEPARTMENT OF HEALTH

March 10, 1999

Fredia S. Wadley, M.D.
Commissioner
Tennessee Department of Health
Cordell Hull Building, Third Floor
425 5th Avenue, North
Nashville, TN 37247

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Should there be any questions concerning this matter, please contact Bill Blanton at (404) 562-7433.

Sincerely,

Eugene A. Grasser
Associate Regional Administrator
Division of Medicaid and State Operations

- volume/capacity of the hospital and other related health care resources
- distance/travel time to other health care facilities in the service area
- any other barriers to accessing health care in the service delivery area

The following is a list of all Tennessee Hospitals with an average daily census of 15 or less in 1997. All of these hospitals meet at least one of the criteria for being designated as a necessary provider. Some of these hospitals are currently for profit and this is noted in the list.

Hospital Name	Licensed beds	Staffed Beds	Swing Beds	Patient days	ADC	Profit Status	Comment
JOHNSON COUNTY HOSPITAL	65	20	14	557	1.5	NFP	Closed in 1998
BAPTIST HICKMAN COMMUNITY HOSPITAL	44	25	10	1808	5.0	NFP	
COFFEE MEDICAL CENTER	60	36	10	2979	8.2	NFP	
BAPTIST THREE RIVERS HOSPITAL	42	42	12	2996	8.2	FP	
TROUSDALE MEDICAL CENTER	34	25	8	3242	8.9	NFP	Satellite of Carthage
METHODIST HOSPITAL OF MCKENZIE	65	27	5	3465	9.5	NFP	
GIBSON GENERAL HOSPITAL	100	73	0	3474	9.5	NFP	
CUMBERLAND RIVER HOSPITAL NORTH	27	27	10	3666	10.0	FP	
COLUMBIA EMERALD HODGSON HOSPITAL	24	12	0	3732	10.2	FP	Satellite of Col.Southern TN Med.C
BLEDSOE COUNTY GENERAL HOSPITAL	26	26	7	3755	10.3	FP	
COPPER BASIN MEDICAL CENTER	44	44	0	3784	10.4	NFP	
MACON COUNTY GENERAL HOSPITAL	43	43	10	3994	10.9	NFP	
WAYNE MEDICAL CENTER	80	32	15	4117	11.3	NFP	
RHEA MEDICAL CENTER	57	40	8	4298	11.8	NFP	
COLUMBIA TRINITY HOSPITAL	40	31	6	4570	12.5	FP	
COLUMBIA WHITWELL MEDICAL CENTER	52	52	0	4617	12.6	FP	Satellite of Grandview
METHODIST HAYWOOD PARK HOSPITAL, INC.	62	44	10	4697	12.9	NFP	
BOLIVAR GENERAL HOSPITAL	61	57	10	4725	12.9	NFP	
MCNAIRY COUNTY GENERAL HOSPITAL	86	48	0	4814	13.2	NFP	
METHODIST HOSPITAL OF LEXINGTON	52	35	11	4970	13.6	NFP	
MARSHALL MEDICAL CENTER	119	77	0	5179	14.2	NFP	
CUMBERLAND RIVER HOSPITAL SOUTH	41	41	10	5198	14.2	FP	Satellite of Cumberland River North
CAMDEN GENERAL HOSPITAL	83	35	0	5247	14.4	NFP	
BAPTIST MEMORIAL HOSP. LAUDERDALE	70	67	10	5297	14.5	NFP	
JEFFERSON MEMORIAL HOSPITAL	67	51	14	5312	14.6	NFP	
BAPTIST PERRY COMMUNITY HOSPITAL	53	53	9	5361	14.7	FP	
MEDICAL CENTER OF MANCHESTER	49	49	0	5581	15.3	FP	
WHITE COUNTY COMMUNITY HOSPITAL	60	60	0	5632	15.4	FP	

Additional rural hospitals closed before 1997 but within the past 5 years
Lewis county closed in 1996
Baptist Hospital-Roane Co. closed in 1997.

(73) Psychologist. A person currently licensed as such by the Tennessee Board of Examiners in Psychology.

(74) Qualified Emergency Medical Service Personnel. Includes, but shall not be limited to, emergency medical technicians, paramedics, or other emergency services personnel, providers, or entities acting within the usual course of their professions, and other emergency responders.

(75) Radiological Technologist. A person currently registered as such by the American Society of Radiological Technologists.

(76) Reasonably Available. Readily able to be contacted without undue effort and willing and able to act in a timely manner considering the urgency of the patient's health care needs. Such availability shall include, but not be limited to, availability by telephone.

(77) Registered Health Information Administrator (RHIA). A person currently registered as such by the American Health Information Management Association.

(78) Registered Health Information Technician (RHIT). A person currently accredited as such by the American Health Information Management Association.

(79) Registered Nurse. A person currently licensed as such by the Tennessee Board of Nursing.

(80) Rural Area. A county classified by the federal Office of Management and Budget (OMB) as rural, all counties, excluding Davidson, Hamilton, Knox, and Shelby, currently defined as rural in Chapter 1200-20-11 of the Tennessee Comprehensive Rules and Regulations, or an area outside of a county or part of a county previously classified as rural by the OMB and reclassified by the OMB as a metropolitan statistical area as of June 6, 2003.

(81) Satellite Hospital. A freestanding hospital licensed with a parent hospital that is on separate premises and operated under the same management.

(82) Shall or Must. Compliance is mandatory.

(83) Social Worker. A person who has at least a bachelor's degree in Social Work or related field, and preferably, two (2) years medical social work or other community based work experience.

(84) Stabilize. To provide such medical treatment of the emergency medical condition as may be necessary to assure, within reasonable medical probability, that the condition will not materially deteriorate due to the transfer as determined by a physician or other qualified medical personnel when a physician is not readily available.

(85) State. A state of the United States, the District of Columbia, the Commonwealth of Puerto Rico, or a territory or insular possession subject to the jurisdiction of the United States.

(86) Student. A person currently enrolled in a course of study that is approved by the appropriate licensing board.

(87) Supervising Health Care Provider. The designated physician or, if there is no designated physician or the designated physician is not reasonably available, the health care provider who has undertaken primary responsibility for an individual's health care.

(88) Surgical Technologist. A person who works under supervision to facilitate the safe and effective conduct of invasive surgical procedures. This individual is usually employed by a hospital, medical office, or surgical center and supervised during the surgical procedure

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mapquest

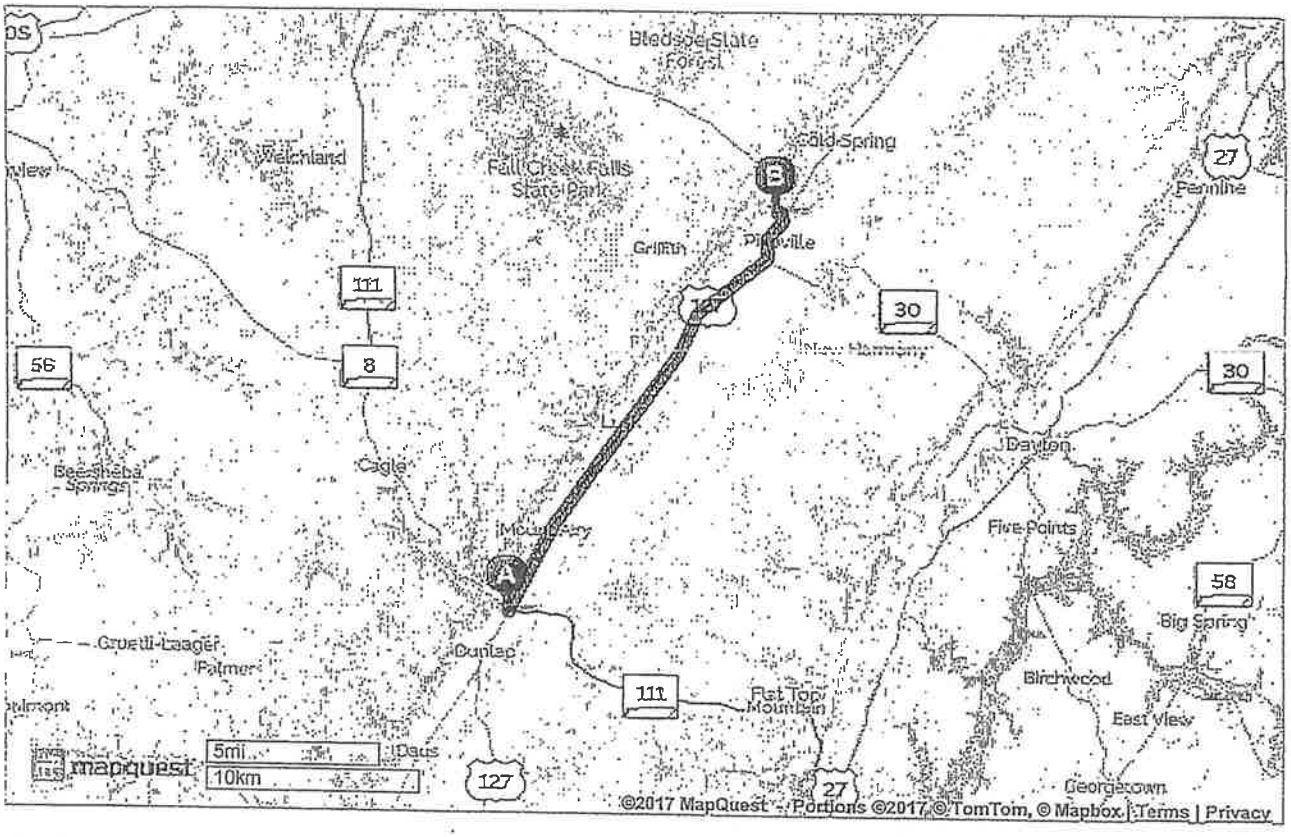
Trip to:

Erlanger Bledsoe Hospital
71 Wheelertown Ave
Pikeville, TN 37367
(423) 447-2112
19.76 miles / 24 minutes
Notes

Proposed Site of New Hospital

	17399 Rankin Ave, Dunlap, TN 37327-7028	Download Free App
	1. Start out going **north** on **Rankin Ave / US-127 N / TN-28 / TN-8** toward **Russell St**. Continue to follow **US-127 N / TN-28**. Map	**19.2 Mi** *19.2 Mi Total*
30	2. Turn **left** onto **State Route 30 / TN-30**. Map *State Route 30 is just past Old State Highway 28*	**0.4 Mi** *19.6 Mi Total*
	3. Take the 1st **left** onto **Wheelertown Ave**. Map *If you reach Buckshot Ln you've gone a little too far*	**0.2 Mi** *19.8 Mi Total*
	4. **71 WHEELERTOWN AVE** is on the **right**. Map *If you reach Buckshot Ln you've gone about 0.1 miles too far*	
	Erlanger Bledsoe Hospital 71 Wheelertown Ave, Pikeville, TN 37367 (423) 447-2112 > Current CAH location	

Total Travel Estimate: **19.76 miles - about 24 minutes**



198

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Trip to:

[463 - 463] US 127 Byp

Pikeville, TN 37367

17.95 miles / 20 minutes

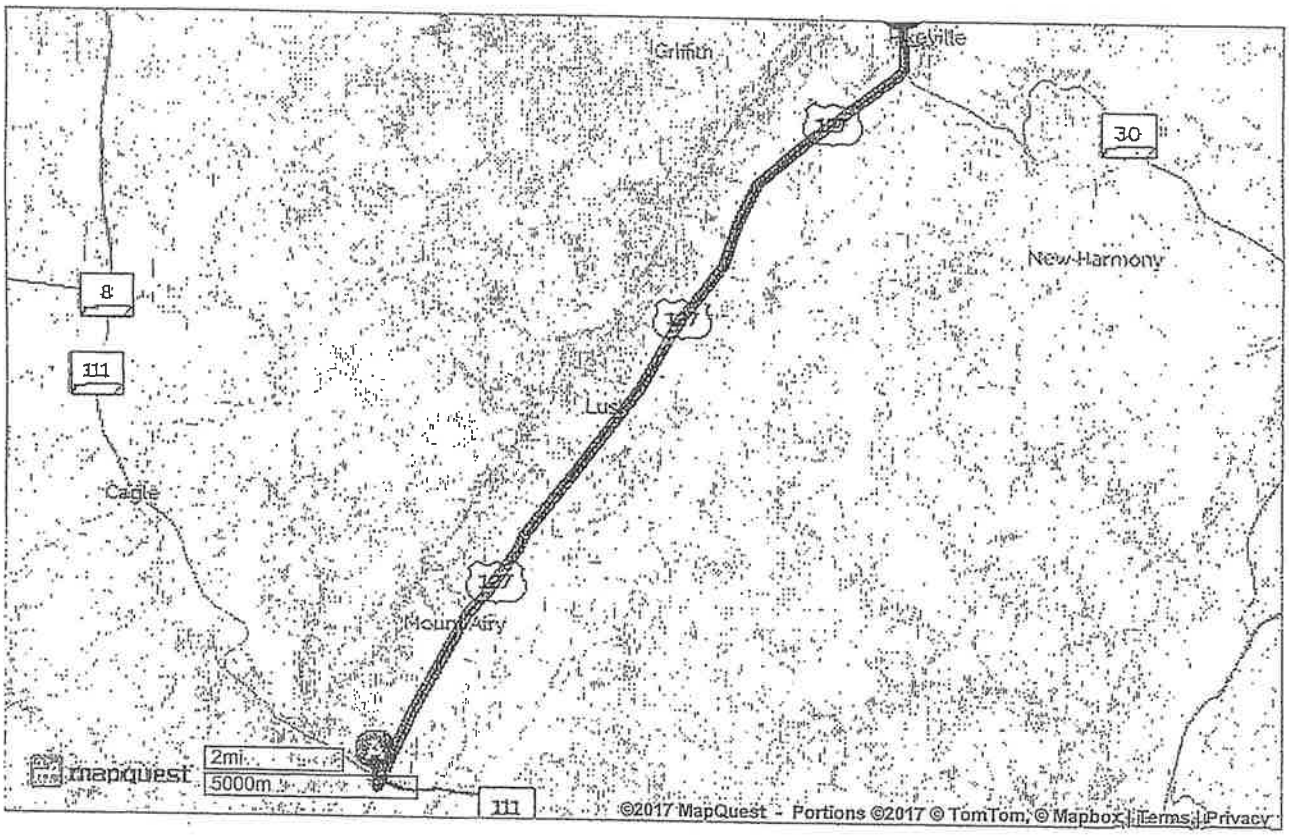
Notes

	17399 Rankin Ave, Dunlap, TN 37327-7028	Download Free App
	1. Start out going **north** on **Rankin Ave / US-127 N / TN-28 / TN-8** toward **Russell St**. Continue to follow **US-127 N / TN-28**. Map	**18.0 Mi** *18.0 Mi Total*
	2. **[463 - 463] US 127 BYP**. Map *Your destination is 0.3 miles past Main St* *If you reach Sequatchie Rd you've gone about 0.3 miles too far*	
	[463 - 463] US 127 Byp, Pikeville, TN 37367	

A= Proposed site for Hospital

B = Proposed site for Provider Based ED

Total Travel Estimate: **17.95 miles - about 20 minutes**



200

mapquest

Trip to:

[463 - 463] US 127 Byp

Pikeville, TN 37367

20.11 miles / 28 minutes

Notes

Rhea Medical Center
9400 Rhea County Hwy, Dayton, TN 37321
(423) 775-1121

Download Free App

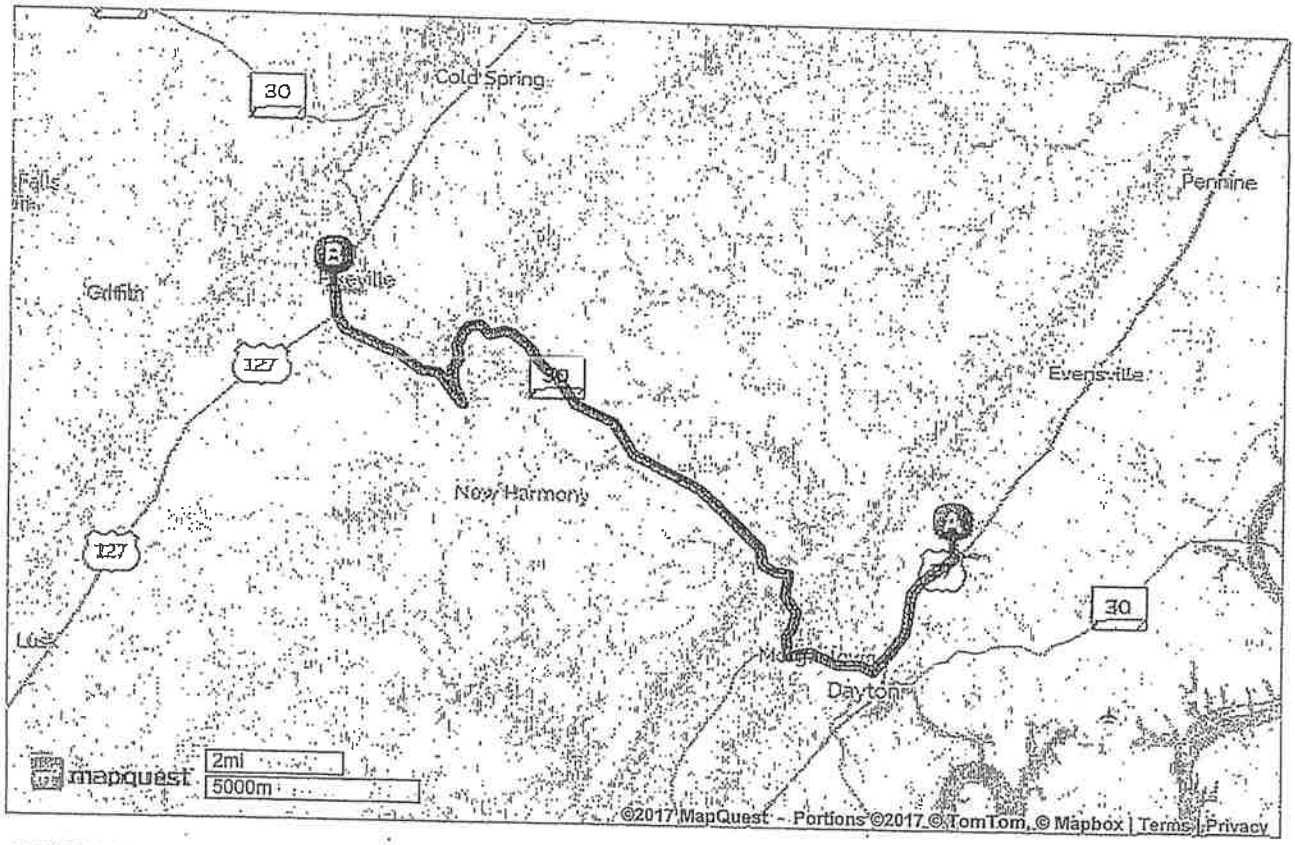
1. Start out going **southwest** on **Rhea County Hwy / US-27 S / TN-29** toward Lower Fine Ln. Map	**2.4 Mi** *2.4 Mi Total*
2. Turn **slight right** onto **Access Rd / US-27 Bus S / TN-378**. Continue to follow **US-27 Bus S / TN-378**. Map *US-27 Bus S is just past 11th Ave*	**0.5 Mi** *2.9 Mi Total*
3. Turn **right** onto **Dayton Mountain Hwy / TN-30**. Continue to follow **TN-30**. Map *TN-30 is just past 7th Ave* *If you reach Church St you've gone a little too far*	**16.8 Mi** *19.7 Mi Total*
4. Turn **right** onto **US-127 N / TN-30 / TN-28 / Main St**. Continue to follow **US-127 N / TN-30 / TN-28**. Map	**0.4 Mi** *20.1 Mi Total*
5. **[463 - 463] US 127 BYP**. Map *If you reach Sequatchie Rd you've gone about 0.3 miles too far*	

[463 - 463] US 127 Byp, Pikeville, TN 37367

553 US 127 Bypass
Proposed Site for Provider Based ED.

201

Total Travel Estimate: **20.11 miles - about 28 minutes**



202

mapquest

Trip to:

[463 - 463] US 127 Byp
Pikeville, TN 37367
28.28 miles / 34 minutes
Notes

Cumberland Medical Center
421 S Main St, Crossville, TN 38555
(931) 484-9511

Download Free App

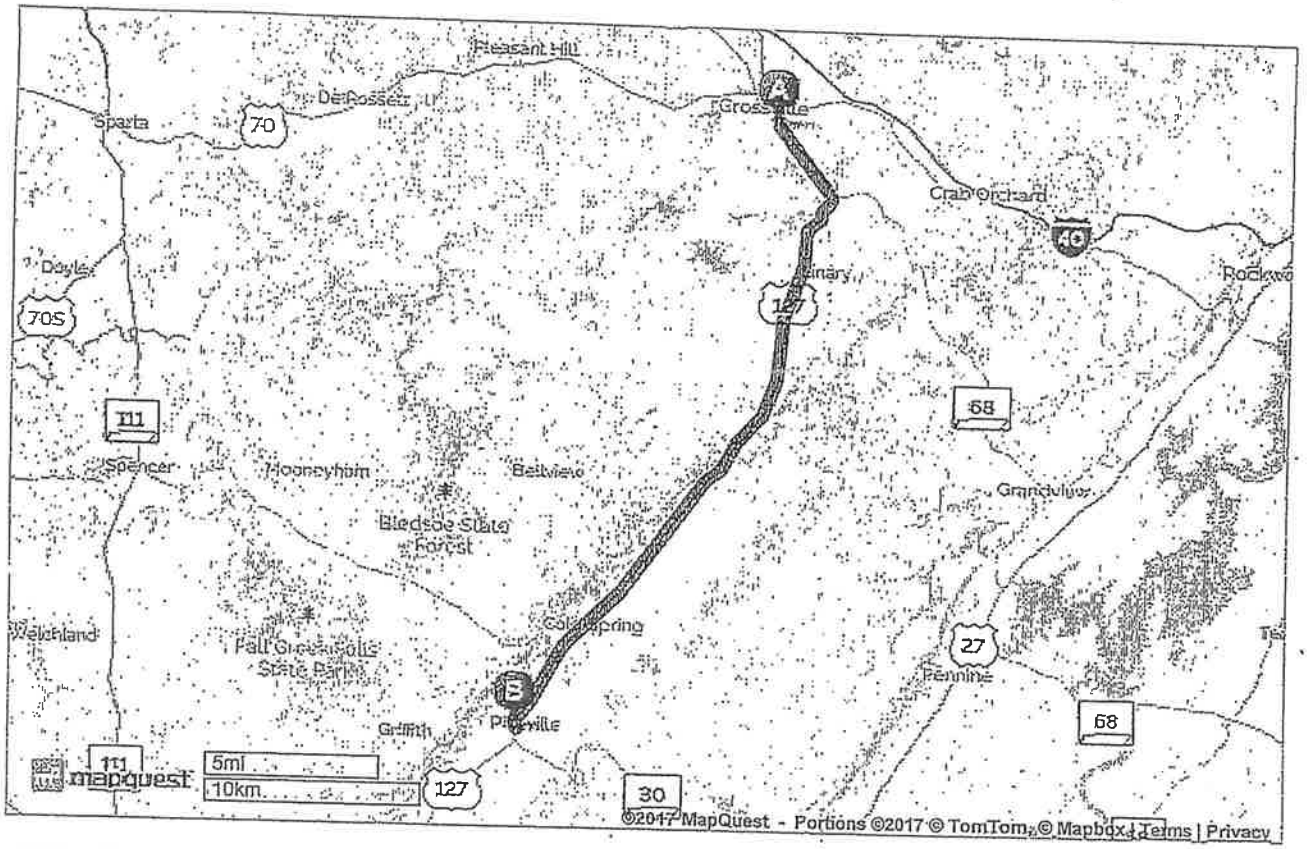
1. Start out going **south** on **S Main St / US-127 S / TN-28** toward **Justice Center Dr.** Continue to follow **US-127 S / TN-28.** Map	**3.3 Mi** *3.3 Mi Total*
2. Turn **slight right** onto **Highway 127 S / US-127 S / TN-28.** Continue to follow **US-127 S / TN-28.** Map *US-127 S is 0.1 miles past Old Homestead Hwy*	**25.0 Mi** *28.3 Mi Total*
3. **[463 - 463] US 127 BYP.** Map *Your destination is 0.3 miles past Sequatchie Rd* *If you reach Main St you've gone about 0.3 miles too far*	

[463 - 463] US 127 Byp, Pikeville, TN 37367

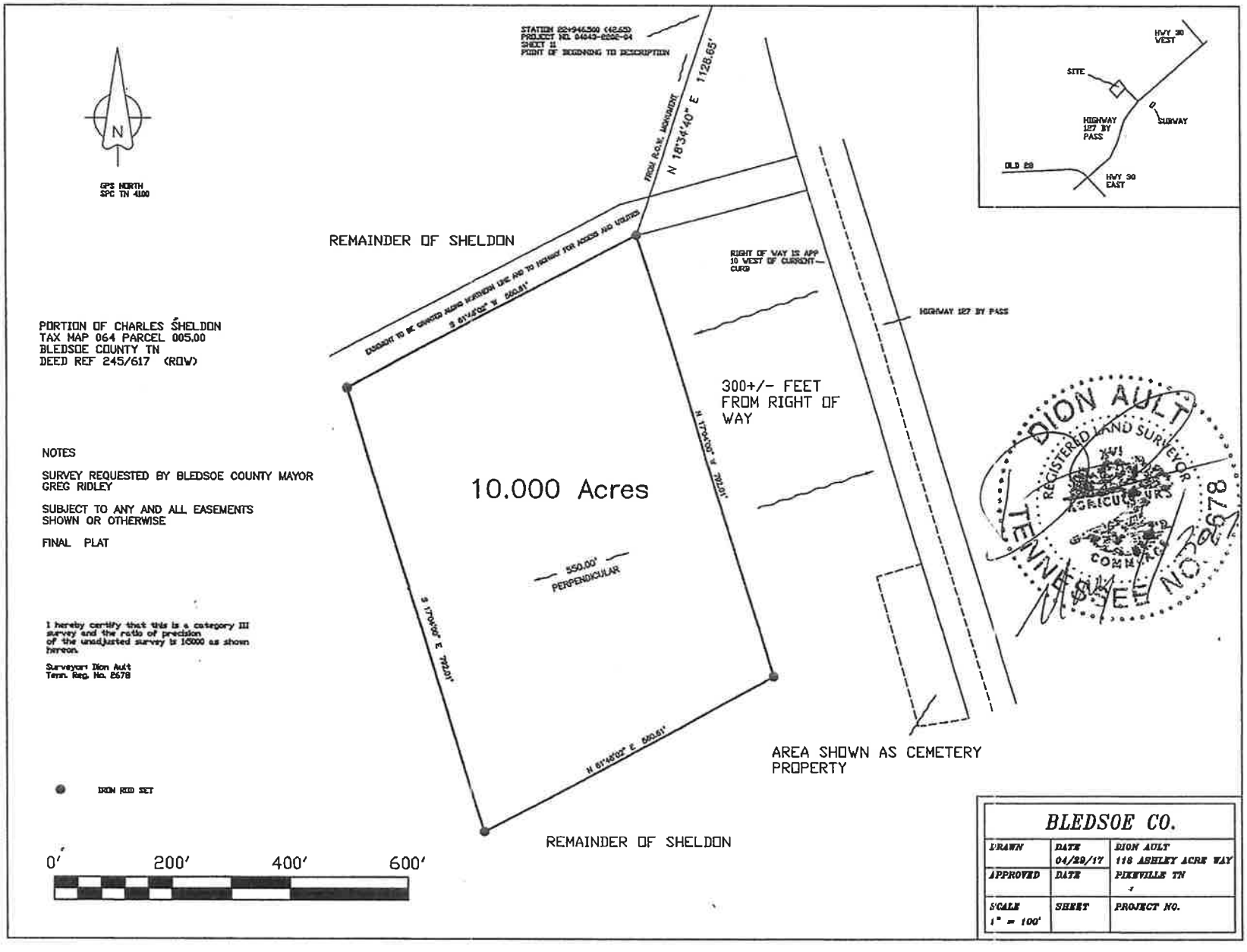
553 US 127 Bypass

Proposed Site for Provider Based ED

Total Travel Estimate: **28.28 miles - about 34 minutes**



Description	Section / Item
Erlanger Sequatchie Valley Regional Hospital - Site Plan	A-6-B
Erlanger Sequatchie Valley Regional Hospital - Floor Plans	A-6-B



PORTION OF CHARLES SHELDON
TAX MAP 064 PARCEL 005.00
BLEDSOE COUNTY TN
DEED REF 245/617 (ROW)

NOTES

SURVEY REQUESTED BY BLEDSOE COUNTY MAYOR GREG RIDLEY

SUBJECT TO ANY AND ALL EASEMENTS SHOWN OR OTHERWISE

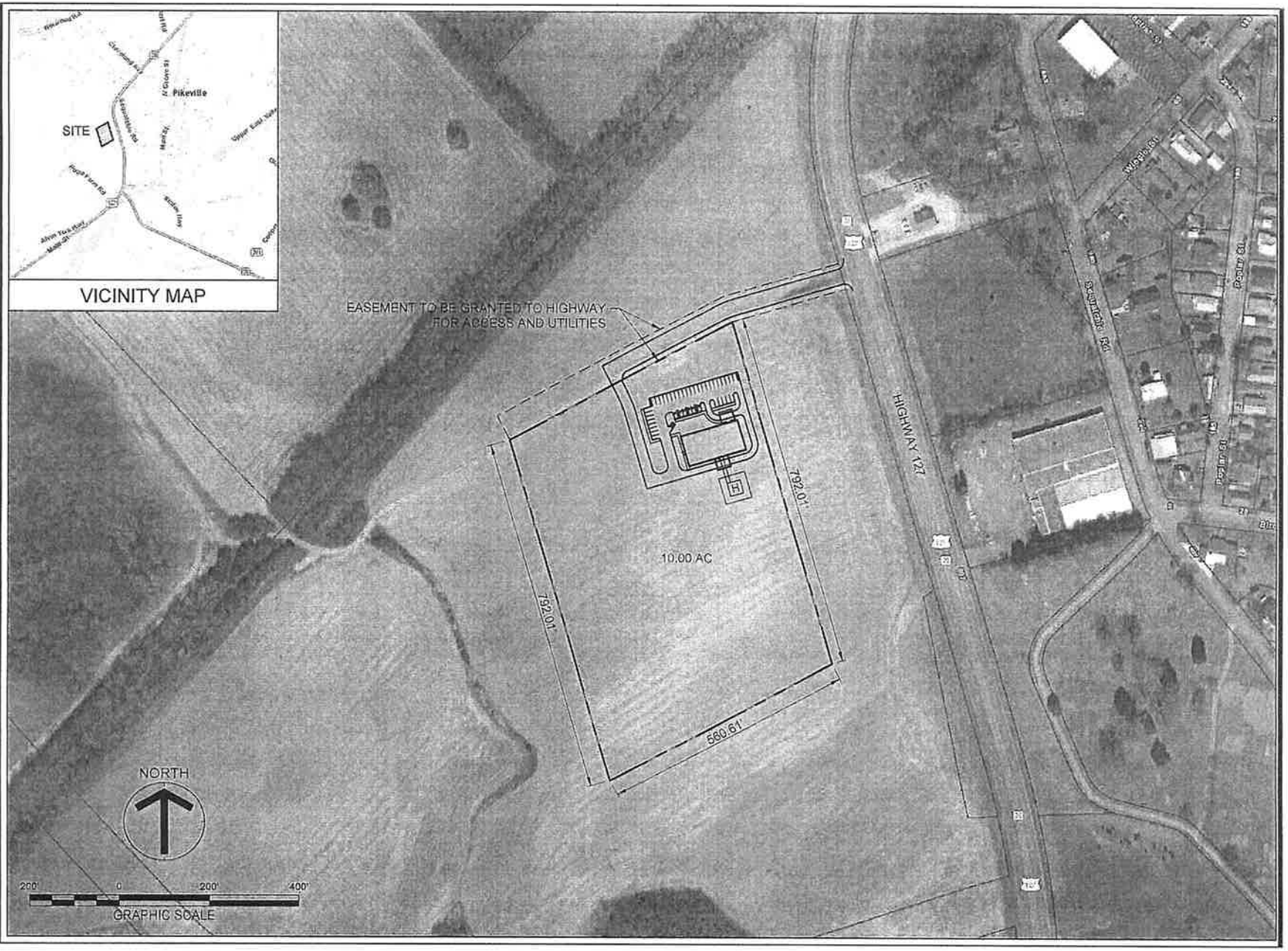
FINAL PLAT

I hereby certify that this is a category III survey and the ratio of precision of the unadjusted survey is 1:5000 as shown hereon.

Surveyor: Dion Ault
Tenn. Reg. No. 2578

IRON ROD SET

BLEDSOE CO.		
DRAWN	DATE 04/29/17	DION AULT 116 ASHLEY ACRE WAY
APPROVED	DATE	PIKEVILLE TN
SCALE 1" = 100'	SHEET	PROJECT NO.



Drawn By: DSW
Checked By: CHK
Approved By: APR

G:\192651\5\Erlanger\Bledsoe County\CON Site Study\Site Layout_CON.dwg - Rudolph, Trey - 7/26/2017 1:13:42 PM

G S & P

Design Services For The Built Environment

GRESHAM SMITH AND PARTNERS

www.greshamsmith.com

ERLANGER SEQUATCHIE VALLEY REGIONAL HOSPITAL
BLEDSOE CAMPUS
US HWY 127 BY-PASS, PIKEVILLE, TN

206

NOT FOR CONSTRUCTION

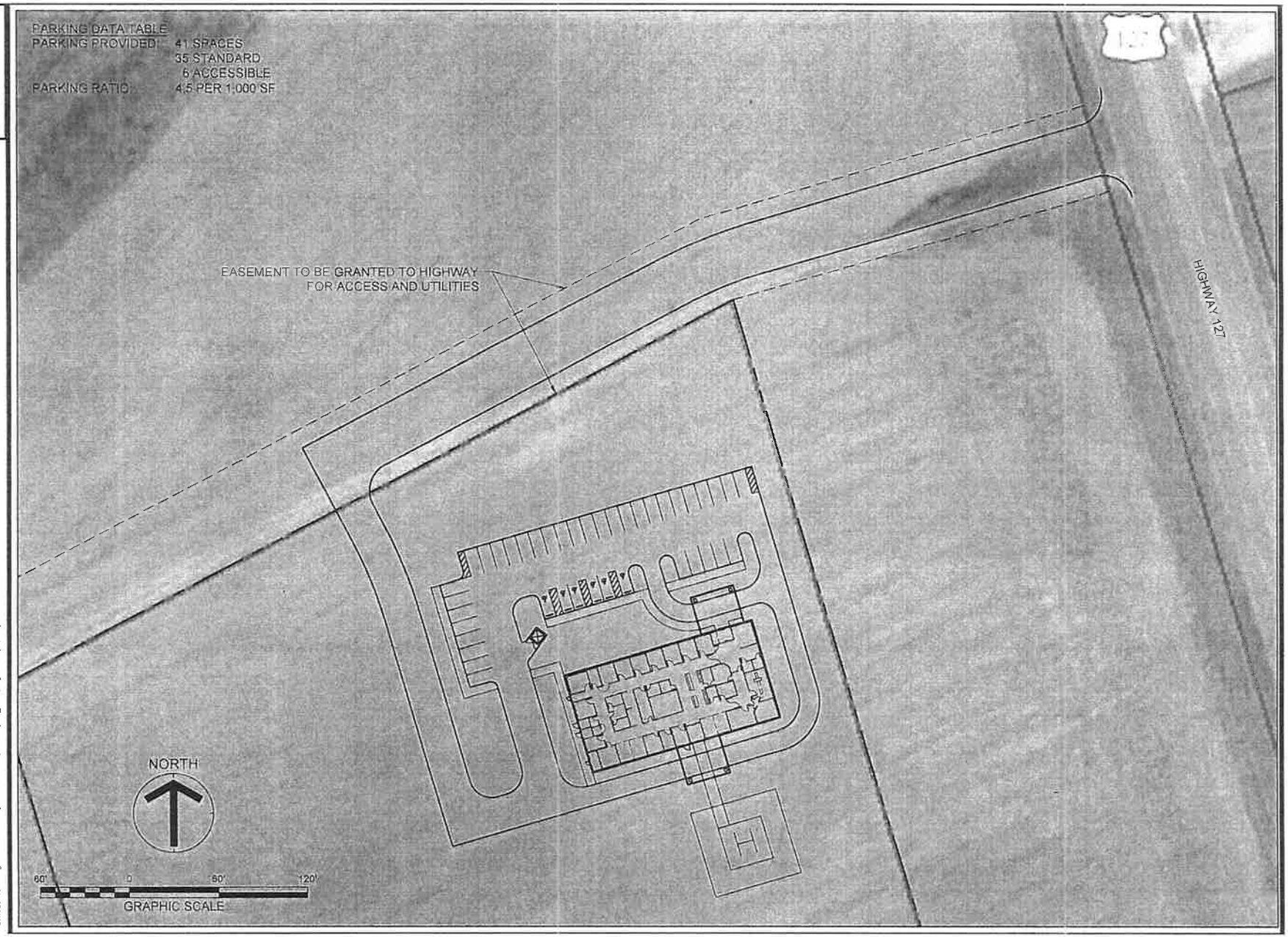
Revision		
No.	Date	Description
1	10/12/2017	
2	11/13/2017	
3	12/11/2017	
4	12/18/2017	
5	12/21/2017	

OVERALL SITE EXHIBIT

EXH-C1

PROJECT: Project Number
DATE: July 26, 2017

LINE IS 3 INCHES WHEN PRINTED FULL SIZE
FULL SHEET SIZE = 24"X36"



Drawn By: BRR
Checked By: CHE
Approved By: APR

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G S & P

Design Services For The Built Environment

GRESHAM SMITH AND PARTNERS

www.greshamsmith.com

ERLANGER SEQUATCHIE VALLEY REGIONAL HOSPITAL
BLEDSOE CAMPUS

US HWY 127 BY-PASS, PIKEVILLE, TN

207

NOT FOR CONSTRUCTION

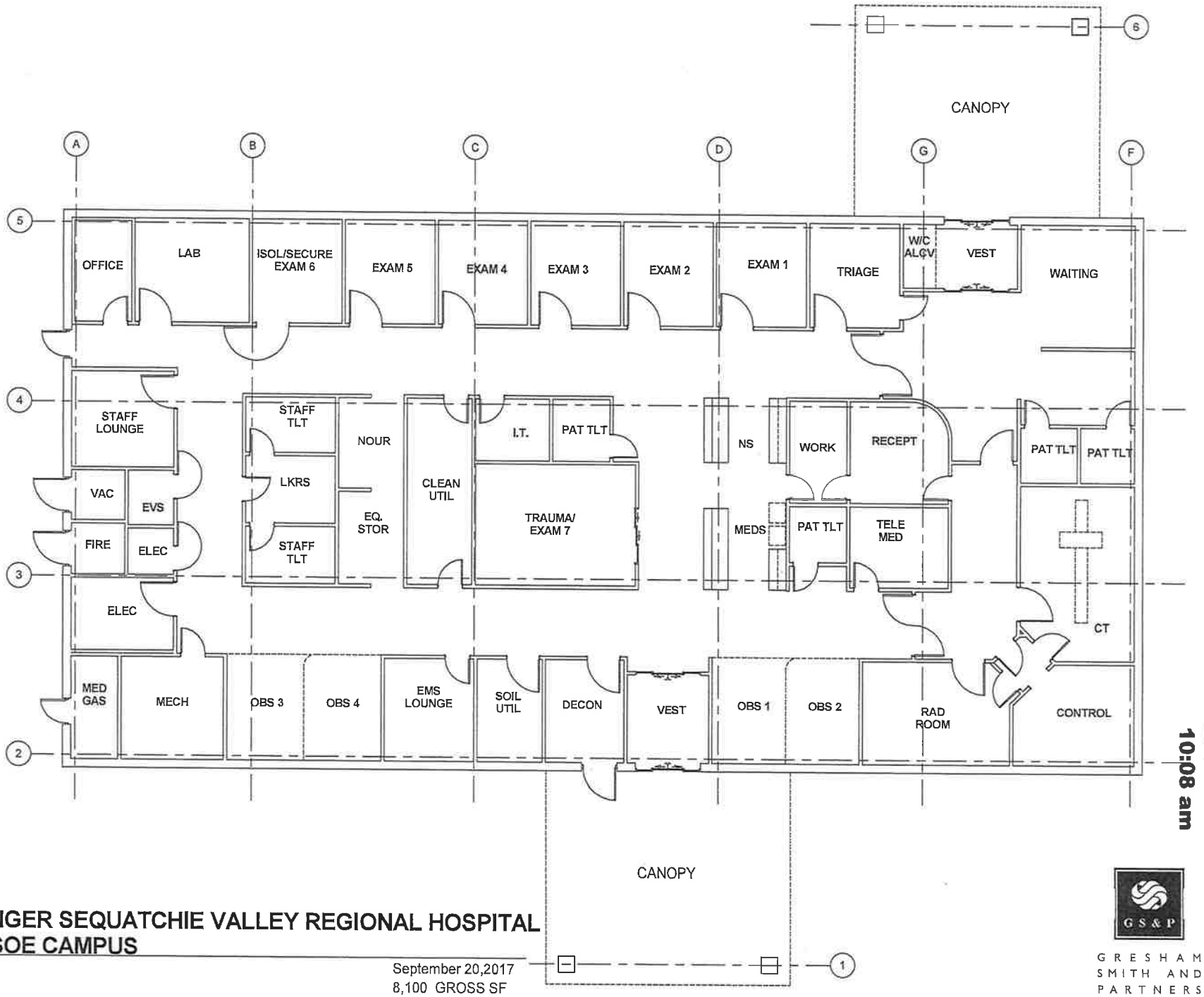
Revision		
No.	Date	Description
1	[illegible]	
2	[illegible]	
3	[illegible]	
4	[illegible]	
5	[illegible]	

DETAILED SITE EXHIBIT

EXH-C2

PROJECT: Project Number
DATE: July 26, 2017

LINE IS 3 INCHES WHEN PRINTED FULL SIZE
FULL SHEET SIZE = 24"X36"



208

ERLANGER SEQUATCHIE VALLEY REGIONAL HOSPITAL
BLEDSOE CAMPUS

1

September 20,2017
8,100 GROSS SF

GS&P
GRESHAM SMITH AND PARTNERS

SUPPLEMENTAL #1
EXHIBIT F
September 22, 2017
10:08 am

Description	Section / Item
Medicare Indicators	B-ED
CFO Letter For ED	B-ED

Data.Medicare.gov

Get started | Info | Developers | Search | SIGN IN

Timely and Effective Care - Hospital

Timely and Effective Care measures - provider data. This data set includes provider-level data for measures of heart attack care, ▸

Find in this Dataset

Manage | More Views | Filter | Visualize | Export | Embed | Abou

	Phone Number	Condition	Measure ID	Measure Name	Score	Sample
86659	(423) 447-2112	Emergency Department	ED_1b	ED1	Not Available	Not Available
86660	(423) 447-2112	Emergency Department	ED_2b	ED2	Not Available	Not Available
86661	(423) 447-2112	Emergency Department	EDV	Emergency department volume	Low (0 - 19,999 patients annually)	
86662	(423) 447-2112	Preventive Care	IMM_2	Immunization for influenza	Not Available	Not Available
86663	(423) 447-2112	Preventive Care	IMM_3_OP_27_FAC_ADHPC	Healthcare workers given influenza vaccination	Not Available	Not Available
86664	(423) 447-2112	Heart Attack or Chest Pain	OP_1	Median Time to Fibrinolysis	Not Available	Not Available
86665	(423) 447-2112	Emergency Department	OP_18b	OP 18	95	169
86666	(423) 447-2112	Heart Attack or Chest Pain	OP_2	Fibrinolytic Therapy Received Within 30 Minutes of ED Arrival	Not Available	Not Available
86667	(423) 447-2112	Emergency Department	OP_20	Door to diagnostic eval	25	164
86668	(423) 447-2112	Emergency Department	OP_21	Median time to pain med	49	25
86669	(423) 447-2112	Emergency Department	OP_22	Left before being seen	2	15682
86670	(423) 447-2112	Emergency Department	OP_23	Head CT results	Not Available	Not Available
86671	(423) 447-2112	Colonoscopy care	OP_29	Endoscopy/polyp surveillance: appropriate follow-up interval for normal c	Not Available	Not Available
86672	(423) 447-2112	Colonoscopy care	OP_30	Endoscopy/polyp surveillance: colonoscopy interval for patients with a his	Not Available	Not Available
86673	(423) 447-2112	Cataract surgery outcome	OP_31	Improvement in Patient's Visual Function within 90 Days Following Catarac	Not Available	Not Available
86674	(423) 447-2112	Heart Attack or Chest Pain	OP_3b	Median Time to Transfer to Another Facility for Acute Coronary Interventior	Not Available	Not Available
86675	(423) 447-2112	Heart Attack or Chest Pain	OP_4	Aspirin at Arrival	99	84
86676	(423) 447-2112	Heart Attack or Chest Pain	OP_5	Median Time to ECG	9	86
86677	(423) 447-2112	Pregnancy and Delivery Care	PC_01	Percent of newborns whose deliveries were scheduled early (1-3 weeks ea	Not Available	Not Available
86678	(423) 447-2112	Stroke Care	STK_4	Thrombolytic Therapy	Not Available	Not Available
86679	(423) 447-2112	Blood Clot Prevention and Treatment	VTE_5	Warfarin therapy discharge instructions	Not Available	Not Available
86680	(423) 447-2112	Blood Clot Prevention and Treatment	VTE_6	Hospital acquired potentially preventable venous thromboembolism	Not Available	Not Available

erlanger

July 27, 2017

Ms. Melanie M. Hill
Executive Director
State of Tennessee
Health Services & Development Agency
500 Deaderick Street, Suite 850
Nashville, TN 37243

RE: Sequatchie Valley Regional Hospital
Provider Based Emergency Department
Certificate of Need Application

Dear. Ms. Hill:

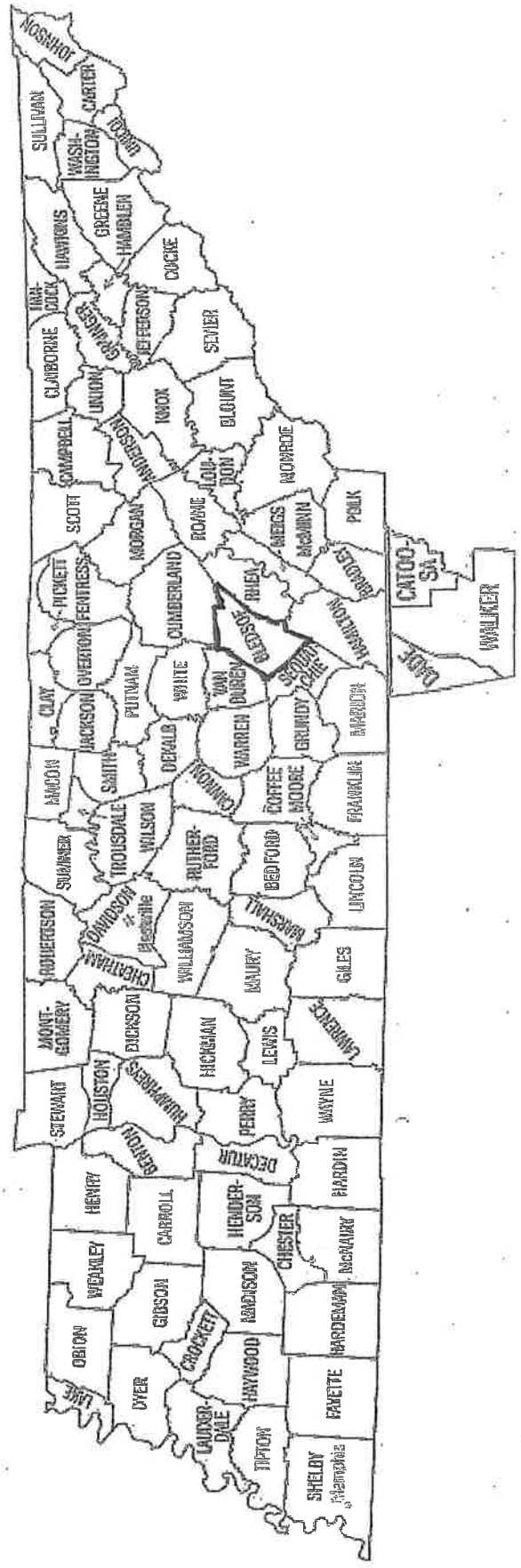
This letter serves to confirm Erlanger's support for development and operation of the provider based emergency department associated with the above referenced Certificate of Need application. Much as we currently do with the Erlanger Bledsoe provider based emergency department, Erlanger will provide all need resources to operate the emergency department inclusive of equipment and staff. Erlanger will also document the cost of maintaining needed resources and will sustain them to insure the provision of high quality care within the emergency services continuum.

If you have questions on the above, please do not hesitate to contact me.

Sincerely,

J. Britton Tabor, CPA, FACHE
Executive Vice President, CFO/Treasurer

Description	Section / Item
Service Area	B-I-3


JOHNSON
CARTER
UNICOI
WASHINGTON
SULLIVAN
GREENE
HAWKINS
HAMBLEN
HANCOCK
GRAINGER
JEFFERSON
CLAIBORNE
UNION
CAMPBELL
CUMBERLAND
SCOTT
MORGAN
ROANE
KNOX
BLOUNT
SEVIER
MONROE
POLK
MCMINN
MEIGS
RHEA
BLEDSOE
SEQUATCHIE
MARION
HAMILTON
BRADLEY
CATOOSA
WALKER
DADE
PICKETT
FENTRESS
OVERTON
PUTNAM
WHITE
VAN BUREN
GRUNDY
CLAY
JACKSON
DEKALB
WARREN
COFFEE
FRANKLIN
MACON
SMITH
CANNON
MOORE
LINCOLN
SUMNER
WILSON
RUTHERFORD
BEDFORD
TROUSDALE
ROBERTSON
DAVIDSON
Nashville
WILLIAMSON
MARSHALL
MAURY
GILES
CHEATHAM
MONTGOMERY
DICKSON
HUMPHREYS
HOUSTON
STEWART
BENTON
PERRY
LEWIS
LAWRENCE
WAYNE
DECATUR
HENRY
CARROLL
HENDERSON
HARDIN
WEAKLEY
GIBSON
CROCKETT
MADISON
CHESTER
MCNAIRY
OBION
DYER
LAKE
HAYWOOD
HARDEMAN
FAYETTE
LAUDERDALE
TIPTON
SHELBY
Memphis

Description	Section / Item
Architect Letter - Construction Cost	B-II-1
Siemens Quote For CT Unit	B-II-1
Siemens Quote For Equipment Maintenance	B-II-1

SUPPLEMENTAL #1
September 22, 2017
10:08 am

GRESHAM
SMITH AND
PARTNERS

September 19, 2017

Mr. Joseph M. Winick, FACHE
Senior Vice President
Planning, Analytics & Business Development
Erlanger Health System
975 East 3rd Street
Chattanooga, Tennessee 37403

Subject: **Project Fee for**
Satellite Emergency Department
Sequatchie Valley Regional Hospital
Chattanooga, Tennessee
GS&P Project No. 19252.23

Dear Joe:

Thank you for engaging Gresham, Smith and Partners on the design and development of the above-referenced project. We are excited to be working with Erlanger on the new satellite emergency department to serve residents of the Sequatchie Valley.

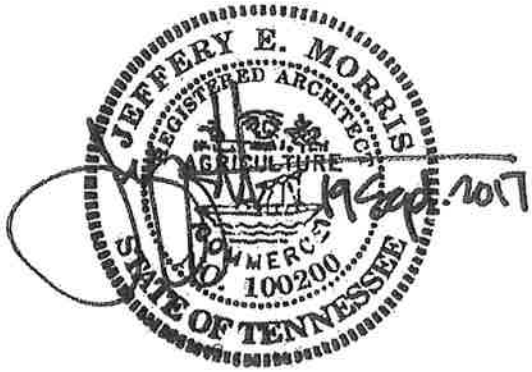
Based on plans developed to date and our review of the site and building conditions, we estimate construction costs of the project, net of contingencies, equipment and related expenses to be $302.89 per square foot for the satellite emergency department with 8,100 SF for a total construction cost of $2,453,400. The site for the emergency department is suitable for its intended use and will provide convenient access from adjacent roadways.

Plans for design and of the building will comply with the latest AIA standards and guidelines for design and construction of hospitals as prescribed by the Tennessee Department of Health.

Please let us know if you need additional information.

Sincerely,

Jeffery E. Morris, AIA, LEED AP, LEAN, EDAC
Principal



GRESHAM
SMITH AND
PARTNERS

July 24, 2017

Mr. Joseph M. Winick, FACHE
Senior Vice President
Planning, Analytics & Business Development
Erlanger Health System
975 East 3rd Street
Chattanooga, TN 37403

Subject: **Sequatchie Valley Regional Hospital**

Dear Joe:

Thank you for engaging Gresham Smith and Partners on the design and development of the above reference project. We are excited to be working with Erlanger on the new hospital and associated emergency department to serve residents of the Sequatchie Valley.

Based on plans developed to date and our review of the sites and building conditions, we estimate construction cost of the project, net of contingencies, equipment and related expenses at $322.00 per square foot which includes the hospital with 61,500 SF and the emergency department with 8,100 SF for a total construction cost of $22,411,900.00. The sites for the hospital and for the emergency department are both suitable for their intended uses; both will also provide convenient access from adjacent roadways.

Plans for design of the buildings will comply with the latest AIA standards and guidelines for design and construction of hospitals as prescribed by the Tennessee Department of Health.

Please let us know if you need additional information.

Sincerely,

Jeffery Morris, AIA, LEED AP, LEAN, EDAC
Principal

JEFFERY E. MORRIS
REGISTERED ARCHITECT
ARCHITECTURE
COMMERCE
NO. 100200
STATE OF TENNESSEE
7-24-2017

Description	Section / Item
Funding - Sequatchie County, Tennessee	B-II-2

Bledsoe County Courthouse
P.O. Box 149
Pikeville, TN 37367

Bledsoe County, Tennessee
Gregg Ridley, County Mayor

Phone 423-447-6855
Fax 423-447-7265
E-mail: *bledsoemayor@bledsoe.net*

September 8, 2017

Financing Letter:

To: Whom it may concern.
From: Bledsoe County Mayor Gregg Ridley

RE: New MOB Financing

This letter will confirm our discussion and our commitment to provide financing for your new Emergency Department in the amount of $4,800,000. This is a preliminary commitment, subject to receipt of necessary support documents, underwriting and other pertinent information. The commitment is good for 12 months. The note will be payable in full over the course of 25 years and will bear an interest rate of 3.50. This interest rate may change, subject to market conditions for this type of financing.

We look forward to working with you on this project. If we can provide further information, please do not hesitate to contact us.

Sincerely,

Gregg Ridley
Bledsoe County Mayor

SUPPLEMENTAL #1
September 22, 2017
10:08 am

CS SINCE 1931 | CUMBERLAND SECURITIES

September 20, 2017

Stephonie Boyington
Erlanger Hospital

Re: Bledsoe County, Tennessee
Re: Ability to Fund

Dear Ms. Boyington,

Per the County's request, we are writing you this letter to inform you that it is our professional opinion, as the County's Financial Advisor, that the County has access to the capital markets to issue bonds to fund the proposed emergency center.

Cumberland Securities has served as Financial Advisor to more Tennessee cities and counties than any other firm for over 85 years, assisting them in meeting all their capital needs as they arise. Please do not hesitate to contact us if you would like to discuss the funding capacity of the County.

Very truly yours,

Chris Bessler
Senior Vice President
Cumberland Securities Company, Inc.

Cumberland Securities Company, Inc.
P.O. Box 24508 Knoxville, Tennessee 37933
Telephone: (865) 988-2663 Facsimile: (865) 988-1863

Description	Section / Item
Erlanger Interim Financial Statements	B-II-3
Erlanger Audited Financial Statements	B-II-3

Consolidated Interim Financial Statements

March 31, 2017

DO NOT DISSEMINATE - The documents and information contained herein are confidential and protected pursuant to T.C.A. Section 68-11-272 and/or T.C.A. Section 68-11-238, as applicable, and are neither discoverable nor subject to production under Tennessee's Public Records Act or otherwise.

Table of Contents

Erlanger Health System
Executive Summary for the Period Ended
March 31, 2017

The following financial information represents consolidated information for the Erlanger Health System, which includes:

Erlanger Medical Center(EMC) ContinuCare(CUC) Bledsoe (BLEDSOE) Health Centers(SSDA) HMO Trust (HMO)

EMC Key Financial Indicators

- Net income from operations for Erlanger Health System for the month was $5,831,421 compared to a budgeted net income of $4,418,313. Year-to-date net income from operations was $12,067,203 compared to a budgeted net income of $11,475,256.
- Total net income for Erlanger Health System for the month was $5,302,295 compared to a budgeted total net income of $3,514,795. Year-to-date total net income was $5,502,618 compared to a budgeted total net income of $3,882,288.
- Admissions were 17.5% greater than prior year and 0.4% over budget.
- Total cash reserves are $59,997,796 (excluding $107 million for Investment Portfolio and $32 million of funds held by Bond Trustees). Current accounts payable is $38,578,954 for Erlanger Health System. Days cash on hand is 71 days.
- **Net income before interest, taxes, depreciation and amortization (EBITDA) was $34,771,475.**
- Net days in accounts receivable is 55 days.

Monthly Volumes

March had dramatic volume growth even during a month of high spring break vacations. Erlanger East exceeded expectations by virtually tripling prior year volumes. The monthly surgical inpatient volume was 11.1% greater than prior year and 11.2% under budget. Inpatient heart surgeries were 86.1% greater than prior year and were 97.1% over budget. Surgical mix was 27.2% for the month compared to 28.7% for prior year. Orthopedic inpatient surgeries were 13.7% greater than prior year and 10.5% less than budget. Neurosurgery inpatient surgeries 18.8% greater than prior year and 6.3% under budget. Observation days were on target with prior year and 6.6% under budget. Emergency room visits were on target with prior year and 4.0% under budget. Emergency room admits were 12.8% greater than prior year and 6.1% over budget. There were no divert hours and was overall a very strong inpatient volume month.

Income Statement Comments

March's income from operations exceeded prior year income by over $7 million based on tremendous growth as well as cost containment and efficiencies.. Net patient revenue was $6,926,109 over prior year and the effective cost management generated the increase in bottom line profit. Net patient revenue less essential access per adjusted admissions (Including bad debt expense and adjusted for wage index and case mix) was $7,493 as compared to a budget of $8,064. The cost per adjusted admission (including interest expense and excluding unrealized gain/loss on interest swaps) was also under budget at $7,368 compared to a budget of $8,143. The Medicare case mix index was 3.5% over budget (1.97 actual vs. 1.90 budget). Bad debt & charity care as a % of gross patient revenue was 5.71% as compared to a budget of 8.85%. The increase in uncompensated care had a negative impact on the net revenue. Medicare utilization was on target with prior year and 9.6% over budget. Indigent/Self-Pay utilization was 23.0% less than prior year and 21.9% under budget.

Case mix adjusted length of stay increased to 2.75 compared to a budget of 2.73 (0.9% over budget). Paid FTE's per adjusted occupied bed was efficient at 4.54 compared to budget of 5.20 and salary cost per hour was $33.91 compared to a budget of $33.87. Efficient productivity of operations continue to be evident even though staff is working toward the "go live" of e-chart. Also, the staffing cost was appropriately managed during the quarter given the Joint Commission survey. Supplies and drugs per adjusted admission (adjusted for wage index & case mix) was $1,708 compared to a budget of $1,810. Supply management was very effective in March.

Interest income includes a year to date unrealized loss of $2,650,653. The unrealized loss resulted from a market-to-market of the bond investment portfolio due to a rally of the stock market. Since Erlanger holds the bonds to maturity, the loss is not realized.

Balance Sheet Comments

Net patient accounts receivable decrease is reflective of the increased collections. Net days in accounts receivable is 55 days. Days in cash is 71 days and is consistent with our capital plan. The due from third party payors line represents any governmental settlements that are outstanding for fiscal years 2012-2017. The increase in prepaid expenses is due to increased annual payments to vendors amortized appropriately throughout the year. The assets whose use is limited includes $14.7 million in the bond construction fund. The post retirement benefits line item reflects the new GASB pension changes. The reserve for other liabilities includes long term PTO and self insured malpractice liability.

J. Britton Tabor, CFO

ERLANGER HEALTH SYSTEM
Unaudited Consolidated Balance Sheets as of: March 31, 2017

ASSETS	2017	2016
UNRESTRICTED FUND		
CURRENT:		
Cash and temporary investments	$ 59,100,627	$ 50,257,413
Funds held by trustee - current portion	4,407,797	4,502,982
Patient accounts receivable	544,589,652	460,716,265
Less allowances for patient A/R	(416,346,421)	(341,120,035)
Net patient accounts receivable	128,243,231	119,596,230
Other receivables	14,793,774	42,268,418
Due from third party payors	4,235,642	5,696,163
Inventories	18,022,869	14,344,385
Prepaid expenses	9,937,676	9,594,391
Total current assets	238,741,616	246,259,982
PROPERTY, PLANT, AND EQUIPMENT		
Net property, plant and equipment	216,913,311	170,569,529
LONG-TERM INVESTMENTS	897,169	699,429
OTHER ASSETS:		
Assets whose use is limited	134,238,796	166,515,206
Deferred debt issue cost	593,815	763,475
Other assets	1,156,656	1,376,861
Total other assets	135,989,267	168,655,543
DEFERRED OUTFLOWS OF RESOURCES		
Deferred pension adjustments	13,312,022	3,959,346
Deferred amounts from debt refunding	486,983	572,921
TOTAL	**$ 606,340,367**	**$ 590,716,749**

LIABILITIES	2017	2016
UNRESTRICTED FUND		
CURRENT:		
Current maturities of long term debt	$ 4,686,974	$ 4,879,593
Accounts payable/unearned income	38,578,954	50,384,226
Accrued salaries & related liabilities	15,442,835	26,627,090
Due to third party payors	-	111,465
Construction fund payable	1,650,561	1,092,112
Accrued Interest payable	4,375,864	4,568,785
Total current liabilities	64,735,189	87,663,270
POST RETIREMENT BENEFITS (GASB 67/68 & FAS 112)	67,845,960	55,268,993
RESERVE FOR OTHER LIABILITIES	24,189,626	17,773,332
DEFERRED INFLOWS OF RESOURCES		
Deferred pension adjustments	511,392	318,312
Deferred gain from sale-leaseback	3,006,213	3,470,969
LONG - TERM DEBT	202,335,637	207,107,502
FUND BALANCE:		
Unrestricted	201,867,385	196,891,939
Invested in capital assets, net of related debt	35,818,222	16,812,515
Restricted	6,030,743	5,409,917
	243,716,350	219,114,371
TOTAL	**$ 606,340,367**	**$ 590,716,749**

Erlanger Health System

Unaudited Consolidated Statement of Operations

For the periods ended March 31, 2017 and 2016

	Current Month			Year to Date		
	Actual	Budget	Prior Year	Actual	Budget	Prior Year
Net patient service revenue	$ 73,808,243	$ 75,246,947	$ 66,882,134	$ 624,439,301	$ 626,516,782	$ 571,416,285
Other revenue(expense)	4,289,520	3,243,574	3,302,502	32,007,662	29,054,030	25,497,545
Net operating revenue	78,097,763	78,490,520	70,184,636	656,446,962	655,570,813	596,913,830
Expenses						
Salaries and employee benefits	37,568,112	38,617,733	36,200,548	331,155,203	337,660,321	305,191,708
Supplies	10,576,888	10,968,375	11,483,994	93,273,749	92,976,956	83,905,476
Purchased services	15,321,716	14,325,284	14,795,289	128,939,076	125,536,209	118,615,309
Utilities	841,229	908,619	769,523	7,824,816	8,076,214	7,437,035
Drugs	6,960,292	5,877,593	5,703,660	57,230,327	49,956,384	44,221,009
Depreciation	507,615	3,047,888	2,154,300	22,436,183	26,932,466	21,168,381
Insurance & taxes	490,490	326,715	276,948	3,520,405	2,957,007	2,427,024
Total operating expense	72,266,342	74,072,207	71,384,262	644,379,759	644,095,557	582,965,941
Excess rev. over/(under) exp. from operations	5,831,421	4,418,313	(1,199,626)	12,067,203	11,475,256	13,947,889
NONOPERATING INCOME:						
Gain (Losses) on disposal of assets	(9,288)	(21,386)	126	(192,67[illegible])	(189,737)	834,702
Interest Income/Gains (Losses) on Investments	(108,121)	73,154	108,864	(1,110,896) [1]	536,951	1,508,801
Interest expense	(290,314)	(832,726)	(826,270)	(5,194,736)	(7,360,251)	(7,452,584)
Provisions for income tax	(121,403)	(122,560)	(99,995)	(66,283)	(579,930)	(543,364)
Excess rev. over/(under) expenses	$ 5,302,295	$ 3,514,795	$ (2,016,900)	$ 5,502,618	$ 3,882,288	$ 8,295,445
EBITDA	6,385,389	7,483,367	1,009,014	34,771,475	38,612,278	36,265,311
Operating Margin	7.47%	5.63%	-1.71%	1.84%	1.75%	2.34%
Total Margin	6.79%	4.48%	-2.87%	0.84%	0.59%	1.39%

1 - includes unrealized loss on investments of $2,650,653

Erlanger Health System

Unaudited Consolidated Statement of Operations

For the period ended March 31, 2017

	Current Month ACTUAL						
	Primary Health System						
	EMC	BLEDSOE	HMO TRUST	SSDA	Total	CUC	EHS Total
PATIENT SERVICE REVENUE							
Inpatient services	$ 137,411,057	805,547	-	-	138,216,604	-	138,216,604
Outpatient services	111,094,875	4,406,593	-	597,920	116,099,387	1,826,628	117,926,015
Total patient service revenue	$ 248,505,931	5,212,140	-	597,920	254,315,991	1,826,628	256,142,619
REVENUE DEDUCTIONS:							
Certified free care	$ 1,524,437	-	-	(1,042)	1,523,395	17,339	1,540,734
Charity care	7,537,788	306,749	-	241,665	8,086,201	-	8,086,201
Bad debt expense	5,119,338	264,071	-	23,600	5,407,009	30,920	5,437,929
Medicare and medicaid rate adjustments	79,268,540	1,974,744	-	5,112	81,248,397	-	81,248,397
Contractual adjustments and policy discounts	83,696,553	1,550,798	-	60,454	85,307,805	713,309	86,021,114
Total revenue deductions	$ 177,146,656	4,096,362	-	329,790	181,572,807	761,569	182,334,376
NONPATIENT SERVICE REVENUE	$ 809,897	46,660	-	799,387	1,655,945	2,633,575	4,289,520
INVESTMENT IN JOINT VENTURES	$ -	-	-	-	-	-	-
Net operating revenue	$ 72,169,173	1,162,438	-	1,067,517	74,399,129	3,698,634	78,097,763
OPERATING EXPENSE							
Salaries and employee benefits	$ 35,257,951	647,196	-	374,256	36,279,403	1,288,708	37,568,112
Supplies	10,337,708	80,045	-	13,133	10,430,886	146,002	10,576,888
Purchased services	14,704,544	327,175	-	70,743	15,102,461	219,255	15,321,716
Utilities	773,003	33,942	-	11,978	818,923	22,307	841,229
Drugs	5,282,669	41,443	-	6,032	5,330,144	1,630,148	6,960,292
Depreciation	430,816	12,632	-	9,221	452,668	54,947	507,615
Insurance & taxes	461,511	1,598	-	-	463,110	27,380	490,490
Corporate overhead allocation	(164,957)	97,012	-	67,945	-	-	-
Total operating expense	$ 67,083,244	1,241,044	-	553,307	68,877,595	3,388,747	72,266,342
Excess rev. over/(under) exp. from operations	$ 5,085,929	(78,606)	-	514,210	5,521,534	309,887	5,831,421
NONOPERATING INCOME:							
Gain (Losses) on disposal of assets	(4,954)	-	-	-	(4,954)	(4,334)	(9,288)
Interest Income/Gains (Losses) on Investments	(114,636)	(23)	2,440	(149)	(112,367)	4,246	(108,121)
Interest expense	(290,267)	-	-	-	(290,267)	(47)	(290,314)
Provisions for income tax	-	-	-	-	-	(121,403)	(121,403)
EXCESS REVENUES OVER/(UNDER) EXPENSES	$ 4,676,072	(78,628)	2,440	514,061	5,113,945	188,350	5,302,295

Eri ger Health System

Unaudited Consolidated Statement of Operations

For the period ended March 31, 2017

	YTD ACTUAL						
	Primary Health System						
	EMC	BLEDSOE	HMO TRUST	SSDA	Total	CUC	EHS Total
PATIENT SERVICE REVENUE							
Inpatient services	$ 1,157,137,070	5,122,342	-	-	1,162,259,412	-	1,162,259,412
Outpatient services	929,805,255	37,939,639	-	4,886,772	972,631,667	15,182,334	987,814,001
Total patient service revenue	$ 2,086,942,326	43,061,981	-	4,886,772	2,134,891,079	15,182,334	2,150,073,413
REVENUE DEDUCTIONS:							
Certified free care	$ 10,791,521	-	-	(9,374)	10,782,147	225,858	11,008,006
Charity care	87,803,908	2,188,771	-	2,041,200	92,033,880	-	92,033,880
Bad debt expense	64,760,294	2,455,170	-	216,269	67,431,733	408,558	67,840,290
Medicare and medicaid rate adjustments	648,425,294	15,477,473	-	17,680	663,920,447	-	663,920,447
Contractual adjustments and policy discounts	672,584,321	11,734,829	-	486,145	684,805,294	6,026,196	690,831,490
Total revenue deductions	$ 1,484,365,338	31,856,244	-	2,751,920	1,518,973,501	6,660,612	1,525,634,112
NONPATIENT SERVICE REVENUE	$ 9,656,224	529,293	-	2,886,910	13,072,427	18,789,498	31,861,925
INVESTMENT IN JOINT VENTURES	$ 145,737	-	-	-	145,737	-	145,737
Net operating revenue	$ 612,378,950	11,735,030	-	5,021,763	629,135,742	27,311,220	656,446,962
OPERATING EXPENSE							
Salaries and employee benefits	$ 311,077,438	5,789,227	-	3,535,168	320,401,833	10,753,370	331,155,203
Supplies	91,164,251	593,645	-	87,630	91,845,525	1,428,224	93,273,749
Purchased services	123,145,937	3,070,409	-	633,283	126,849,629	2,089,447	128,939,076
Utilities	7,306,919	209,930	-	120,282	7,637,131	187,685	7,824,816
Drugs	44,795,735	280,788	-	119,339	45,195,862	12,034,465	57,230,327
Depreciation	21,755,207	118,035	-	108,605	21,981,847	454,336	22,436,183
Insurance & taxes	3,260,499	22,320	-	2,455	3,285,275	235,130	3,520,405
Corporate overhead allocation	(1,458,011)	857,463	-	600,548	-	-	-
Total operating expense	$ 601,047,975	10,941,818	-	5,207,309	617,197,102	27,182,657	644,379,759
Excess rev. over/(under) exp. from operations	$ 11,330,975	793,212	-	(185,547)	11,938,640	128,563	12,067,203
NONOPERATING INCOME:							
Gain (Losses) on disposal of assets	(142,276)	-	-	-	(142,276)	(50,395)	(192,671)
Interest Income/Gains (Losses) on Investments [1]	(1,101,288)	(297)	3,326	(1,692)	(1,099,950)	(10,945)	(1,110,895)
Interest expense	(5,193,980)	-	-	-	(5,193,980)	(755)	(5,194,736)
Provisions for income tax	-	-	-	-	-	(66,283)	(66,283)
EXCESS REVENUES OVER/(UNDER) EXPENSES	$ 4,893,430	792,915	3,326	(187,238)	5,502,434	184	5,502,619

1 - Includes unrealized loss on investments of $2,650,653

Erlanger Health System

Unaudited Consolidated Statement of Operations

For the period ended March 31, 2017

	Current Month BUDGET						
	Primary Health System						EHS
	EMC	BLEDSOE	HMO TRUST	SSDA	Total	CUC	Total
PATIENT SERVICE REVENUE							
Inpatient services	$ 138,345,901	406,139	-	51,779	138,803,819	-	138,803,819
Outpatient services	110,573,704	4,005,868	-	1,046,440	115,626,012	2,245,380	117,871,392
Total patient service revenue	$ 248,919,605	4,412,007	-	1,098,219	254,429,831	2,245,380	256,675,211
REVENUE DEDUCTIONS:							
Certified free care	$ 816,125	-	-	(1,042)	815,083	37,970	853,053
Charity care	7,978,994	186,887	-	285,500	8,451,381	-	8,451,381
Bad debt expense	13,229,307	306,141	-	45,606	13,581,054	99,120	13,680,174
Medicare and medicaid rate adjustments	72,468,849	1,442,979	-	214,708	74,126,537	-	74,126,537
Contractual adjustments and policy discounts	82,075,890	1,214,895	-	116,744	83,407,529	909,590	84,317,119
Total revenue deductions	$ 176,569,166	3,150,902	-	661,517	180,381,585	1,046,680	181,428,265
NONPATIENT SERVICE REVENUE	$ 1,090,582	53,536	-	250,099	1,394,217	1,832,370	3,226,587
INVESTMENT IN JOINT VENTURES	$ 16,986	-	-	-	16,986	-	16,986
Net operating revenue	$ 73,458,008	1,314,641	-	686,801	75,459,450	3,031,070	78,490,520
OPERATING EXPENSE							
Salaries and employee benefits	$ 36,116,359	625,526	-	586,667	37,328,553	1,289,180	38,617,733
Supplies	10,806,278	59,212	-	21,891	10,887,380	80,995	10,968,375
Purchased services	13,682,944	345,931	-	85,559	14,114,434	210,850	14,325,284
Utilities	855,306	23,468	-	12,295	891,069	17,550	908,619
Drugs	4,793,615	35,932	-	10,696	4,840,243	1,037,350	5,877,593
Depreciation	2,967,619	12,529	-	11,520	2,991,668	56,220	3,047,888
Insurance & taxes	300,845	1,772	-	209	302,825	23,890	326,715
Corporate overhead allocation	(164,957)	97,012	-	67,945	-	-	-
Total operating expense	$ 69,358,010	1,201,382	-	796,781	71,356,172	2,716,035	74,072,207
Excess rev. over/(under) exp. from operations	$ 4,099,998	113,259	-	(109,980)	4,103,278	315,035	4,418,313
NONOPERATING INCOME:							
Gain (Losses) on disposal of assets	(16,986)	-	-	-	(16,986)	(4,400)	(21,386)
Interest Income/Gains (Losses) on Investments	57,223	(33)	83	-	57,274	15,880	73,154
Interest expense	(832,526)	-	-	-	(832,526)	(200)	(832,726)
Provisions for income tax	-	-	-	-	-	(122,560)	(122,560)
EXCESS REVENUES OVER/(UNDER) EXPENSES	$ 3,307,710	113,226	83	(109,980)	3,311,040	203,755	3,514,795

Er. ger Health System

Unaudited Consolidated Statement of Operations

For the period ended March 31, 2017

	YTD BUDGET						
	Primary Health System						EHS
	EMC	BLEDSOE	HMO TRUST	SSDA	Total	CUC	Total
PATIENT SERVICE REVENUE							
Inpatient services	$ 1,168,800,013	3,531,912	-	457,660	1,172,789,586	-	1,172,789,586
Outpatient services	906,295,537	35,360,127	-	9,249,176	950,904,840	17,634,920	968,539,760
Total patient service revenue	$ 2,075,095,551	38,892,039	-	9,706,836	2,123,694,426	17,634,920	2,141,329,346
REVENUE DEDUCTIONS:							
Certified free care	$ 4,833,055	-	-	(9,374)	4,823,681	298,800	5,122,481
Charity care	73,627,843	1,927,280	-	2,899,157	78,454,280	-	78,454,280
Bad debt expense	80,580,571	2,359,847	-	184,793	83,125,212	730,210	83,855,422
Medicare and medicaid rate adjustments	633,905,284	13,554,421	-	2,065,652	649,525,357	-	649,525,357
Contractual adjustments and policy discounts	680,110,121	9,992,581	-	819,301	690,922,003	6,933,020	697,855,023
Total revenue deductions	$ 1,473,056,874	27,834,130	-	5,959,530	1,506,850,534	7,962,030	1,514,812,564
NONPATIENT SERVICE REVENUE	$ 9,650,021	473,188	-	2,210,554	12,333,763	16,570,130	28,903,893
INVESTMENT IN JOINT VENTURES	$ 150,137	-	-	-	150,137	-	150,137
Net operating revenue	$ 611,838,835	11,531,097	-	5,957,861	629,327,793	26,243,020	655,570,813
OPERATING EXPENSE							
Salaries and employee benefits	$ 315,717,348	5,472,209	-	5,080,114	326,269,671	11,390,650	337,660,321
Supplies	91,060,098	520,648	-	191,204	91,771,951	1,205,005	92,976,956
Purchased services	119,779,936	3,058,786	-	756,227	123,594,949	1,941,260	125,536,209
Utilities	7,597,363	207,426	-	108,675	7,913,464	162,750	8,076,214
Drugs	40,232,603	293,096	-	94,535	40,620,234	9,336,150	49,956,384
Depreciation	26,229,925	110,737	-	101,823	26,442,486	489,980	26,932,466
Insurance & taxes	2,722,546	15,658	-	1,843	2,740,047	216,960	2,957,007
Corporate overhead allocation	(1,458,008)	857,463	-	600,548	3	-	3
Total operating expense	$ 601,881,811	10,536,024	-	6,934,970	619,352,805	24,742,755	644,095,560
Excess rev. over/(under) exp. from operations	$ 9,957,024	995,073	-	(977,109)	9,974,988	1,500,265	11,475,253
NONOPERATING INCOME:							
Gain (Losses) on disposal of assets	(150,137)	-	-	-	(150,137)	(39,600)	(189,737)
Interest Income/Gains (Losses) on Investments	505,780	(299)	750	-	506,231	30,720	536,951
Interest expense	(7,358,451)	-	-	-	(7,358,451)	(1,800)	(7,360,251)
Provisions for income tax	-	-	-	-	-	(579,930)	(579,930)
EXCESS REVENUES OVER/(UNDER) EXPENSES	$ 2,954,215	994,774	750	(977,109)	2,972,630	909,655	3,882,285

[redacted]

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY (d/b/a Erlanger Health System and Discretely Presented Component Units)

Audited Combined Financial Statements

Year Ended June 30, 2016

PYA

Certified Public Accountants

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
(d/b/a Erlanger Health System)

Audited Combined Financial Statements

Years Ended June 30, 2016

PYA
Certified Public Accountants

PERSHING YOAKLEY & ASSOCIATES, P.C.
One Cherokee Mills, 2220 Sutherland Avenue
Knoxville, TN 37919
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INDEPENDENT AUDITOR'S REPORT

To the Board of Trustees of
Chattanooga-Hamilton County Hospital Authority
(d/b/a Erlanger Health System):

Report on the Combined Financial Statements

We have audited the accompanying combined financial statements of the business-type activities of Chattanooga-Hamilton County Hospital Authority d/b/a Erlanger Health System (the Primary Health System) and its discretely presented component units, as of and for the year ended June 30, 2016, and the related notes to the combined financial statements, which collectively comprise the Primary Health System's basic combined financial statements as listed in the table of contents.

Management's Responsibility for the Combined Financial Statements

Management is responsible for the preparation and fair presentation of these combined financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of combined financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express opinions on these combined financial statements based on our audit. We conducted our audit in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the combined financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the combined financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the combined financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the Primary Health System's preparation and fair presentation of the combined financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Primary Health System's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and

the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the combined financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the combined financial statements referred to above present fairly, in all material respects, the respective financial position of the business-type activities and the discretely presented component units of the Primary Health System as of June 30, 2016, and the respective changes in financial position and, where applicable, cash flows thereof for the year then ended in accordance with accounting principles generally accepted in the United States of America.

Other Matters

Required Supplementary Information: Accounting principles generally accepted in the United States of America require that the Management's Discussion and Analysis (shown on pages 3 through 10), the Schedule of Changes in Net Pension Liability and Related Ratios (shown on page 45) and the Schedule of Actuarial Contributions (shown on page 46) be presented to supplement the basic combined financial statements. Such information, although not a part of the basic combined financial statements, is required by the Governmental Accounting Standards Board, who considers it to be an essential part of financial reporting for placing the basic combined financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic combined financial statements, and other knowledge we obtained during our audit of the basic combined financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Pershing Yoakley & Associates PC

Knoxville, Tennessee
September 12, 2016

Management's Discussion and Analysis

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
(d/b/a Erlanger Health System)

Management's Discussion and Analysis

Year Ended June 30, 2016

MANAGEMENT'S DISCUSSION AND ANALYSIS

The discussion and analysis of Chattanooga-Hamilton County Hospital Authority d/b/a Erlanger Health System's financial performance provides an overview of financial activities for the fiscal year ended June 30, 2016.

Erlanger Health System (the Primary Health System) is the largest healthcare provider in Southeast Tennessee and the seventh largest public hospital nationwide. The Primary Health System maintains a number of very specialized clinical services such as Level I trauma, Level IV neonatal, kidney transplantation, a Regional Cancer Unit, a full service children's hospital, and open heart surgery, all of which are primarily serviced by five "Life Force" helicopters and supported by subspecialty physicians (residents, faculty and private attending physicians) located on its campuses.

OVERVIEW OF THE COMBINED FINANCIAL STATEMENTS

The combined financial statements consist of two parts: Management's Discussion and Analysis and the combined financial statements. The combined financial statements also include notes that explain in more detail some of the information in the combined financial statements.

The combined financial statements of the Primary Health System offer short-term and long-term financial information about its activities. The combined statements of net position include all of the Primary Health System's assets and liabilities and provide information about the nature and amounts of investments in resources (assets) and the obligations to the Primary Health System's creditors (liabilities). The assets and liabilities are presented in a classified format, which distinguishes between current and long-term assets and liabilities. It also provides the basis for computing rate of return, evaluating the capital structure of the Primary Health System and assessing the liquidity and financial flexibility of the Primary Health System.

All of the fiscal year's revenues and expenses are accounted for in the combined statements of changes in net position. These statements measure the success of the Primary Health System's operations and can be used to determine whether the Primary Health System has successfully recovered all of its costs through the services provided, as well as its profitability and credit worthiness.

The final required financial statement is the combined statement of cash flows. The primary purpose of this statement is to provide information about the Primary Health System's cash receipts, cash payments and net changes in cash resulting from operating, investing, non-capital financing and financing activities. The statement also provides answers to such questions as where did cash come from, what was cash used for, and what was the change in the cash balance during the reporting period?

The analysis of the combined financial statements of the Primary Health System begins on the next page. One of the most important questions asked about the Primary Health System's finances is "Is the financial condition of the Primary Health System as a whole better or worse as a result of the fiscal year's activities?" The combined statements of net position and the combined statements of changes in net position report information about the Primary Health System's activities in a way that will help answer this question. These two statements report the net position of the Primary Health System and changes in the net position. One can think of the Primary Health System's net position – the difference between assets and liabilities – as one way to measure financial health or financial position. Over time, increases or decreases in the Primary Health System's net position is one indicator of whether its financial health is improving or deteriorating. However, one will need to consider other non-financial factors such as changes in economic conditions, regulations and new or changed government legislation.

REPORTING ENTITY

The Chattanooga-Hamilton County Hospital Authority d/b/a Erlanger Health System (the Primary Health System) was created by a private act passed by the General Assembly of the State of Tennessee on March 11, 1976, and adopted by a majority of the qualified voters of Hamilton County, Tennessee on August 5, 1976. The Primary Health System is considered the primary governmental unit for financial reporting purposes. As required by generally accepted accounting principles, these financial statements present the Primary Health System and its component units. The component units discussed below are included in the Primary Health System's reporting entity because of the significance of their operational, financial or other relationships with the Primary Health System.

ContinuCare HealthServices, Inc., Cyberknife of Chattanooga, LLC (Cyberknife), UT-Erlanger Medical Group, Inc. (the Medical Group) and Erlanger Health Plan Trust are legally separate organizations for which the Primary Health System is either financially accountable or owns a majority interest. Accordingly, these organizations represent component units of the Primary Health System. The financial statements of Erlanger Health Plan Trust are blended with the financial statements of the Primary Health System, as the Board of Erlanger Health Plan Trust is substantially the same as that of the Primary Health System and the Primary Health System has operational responsibility.

During fiscal year 2011, Cyberknife was capitalized by contributions from the Primary Health System and certain other minority partners. Cyberknife provides radiation therapy services, specifically robotic stereotactic radiosurgical services through the use of a Cyberknife stereotactic radiosurgery system on the Primary Health System's campus. At June 30, 2016, and 2015, the Primary Health System owned 51% of Cyberknife's outstanding membership units.

The Medical Group was formed on June 30, 2011 and will provide professional healthcare and related services to the public through its employed and contracted licensed physicians and other supporting healthcare providers. The Medical Group has no members; however, the Primary Health System may access the Medical Group's services. The Medical Group is currently not active.

KEY FINANCIAL INDICATORS

The following key financial indicators are for Erlanger Health System as a whole. They are inclusive of the Primary Health System, ContinuCare HealthServices, Inc., and the 51% controlling share of Cyberknife of Chattanooga, LLC.

- Excess revenues over expenses for Erlanger Health System for fiscal year 2016 is $25 million compared to excess of revenue over expenses of $37 million for fiscal year 2015.

- Excess revenues over expenses from operations for Erlanger Health System for fiscal year 2016 is $30 million compared to excess of revenue over expenses of $48 million for fiscal year 2015.

- Total cash and investment reserves at June 30, 2016 are $102 million (excluding $107 million in capital investment funds and $50 million of funds held by Trustees or restricted by donors or others).

- Net days in accounts receivable for Erlanger Health System (utilizing a three month rolling average of net revenue) is 56 days at June 30, 2016 compared to 47 days at June 30, 2015.

- For fiscal year 2016, Erlanger Health System recognized $18.2 million in public hospital supplemental payments from the State of Tennessee compared to $18.8 million in fiscal year 2015.

- For fiscal year 2016, Erlanger Health System recognized $10.4 million in essential access payments from the State of Tennessee compare to $17.4 million in fiscal year 2015.

- For fiscal year 2016, Erlanger Health System recognized $15.1 million in disproportionate share payments from the State of Tennessee. Erlanger Health System did not recognize any such payments for fiscal year 2015.

- For fiscal year 2016, Erlanger Health System recognized $1.1 million in trauma fund payments from the State of Tennessee compared to $1.1 million in fiscal year 2015.

The required bond covenant ratios for fiscal year 2016 compared to bond requirements are as follows:

	June 30, 2016	*Master Trust Indenture*	*Bond Insurer Requirements 04 Series*
Debt service coverage ratio	4.19	1.10	1.35
Current ratio	2.61	N/A	1.50
Days cash on hand	91	N/A	65 days
Indebtedness ratio	50%	N/A	65%

The trust indentures and related documents underlying the bonds contain certain covenants and restrictions. For fiscal year 2016, Erlanger Health System met all required debt covenants.

NET POSITION

Erlanger Health System's net position for the combined Primary Health System and Aggregate Discretely Presented Component Units increased by approximately $26 million in fiscal year 2016. Our analysis focuses on the net position (Table 1) and changes in net position (Table 2) of the Primary Health System's operating activities. Discussion focuses on the Primary Health System and its blended component units.

Net position for the Primary Health System increased from $211 million as of June 30, 2015 to $236 million as of June 30, 2016. The current ratio (current assets divided by current liabilities) decreased from 2.67 in 2015 to 2.56 in 2016 for the Primary Health System.

Table 1- Net Position (in Millions)

	June 30, 2016		*June 30, 2015*	
	Primary Health System	*Discretely Presented Component Units*	*Primary Health System*	*Discretely Presented Component Units*
Current and other assets	**$ 444**	**$ 14**	$ 442	$ 13
Capital assets	**186**	**8**	142	8
Total assets	**630**	**22**	585	21
Deferred ouflows of resources	**15**	**-**	6	-
	$ 645	**$ 22**	$ 590	$ 21

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
(d/b/a Erlanger Health System)

Management's Discussion and Analysis - Continued

Year Ended June 30, 2016

	June 30, 2016		*June 30, 2015*	
	Primary Health System	***Discretely Presented Component Units***	***Primary Health System***	***Discretely Presented Component Units***
Long-term debt outstanding	**$ 208**	**$ -**	$ 213	$ -
Other liabilities	**197**	**6**	163	6
Total liabilities	**405**	**6**	376	6
Deferred inflows of resources	**4**	**-**	4	-
	$ 409	**$ 6**	$ 380	$ 6
Net position				
Net investment in capital assets	**$ 17**	**$ 5**	$ 2	$ 5
Restricted, expendable	**3**	**-**	3	-
Unrestricted	**216**	**11**	206	10
Total net position	**$ 236**	**$ 16**	$ 211	$ 15

Days in cash decreased from 104 days as of June 30, 2015 to 90 days as of June 30, 2016 for the Primary Health System resulting from increased investment in capital.

Days in net accounts receivable for the Primary Health System were 51 days as of June 30, 2015 and 58 days at June 30, 2016, with the increase being attributed to increased volumes.

Capital assets for the Primary Health System were $186 million as of June 30, 2016. Additions for fiscal year 2016 totaled $31 million while $3 million of assets were retired or sold. Depreciation expense was $25 million for the Primary Health System. Retirement of assets reduced accumulated depreciation by $3 million in fiscal year 2016. Construction in progress was $50 million as of June 30, 2016. Included in construction in progress is the Erlanger East expansion totaling $32 million.

Long-term debt outstanding amounted to $208 million as of June 30, 2016 compared to $213 million as of June 30, 2015.

Other liabilities for the Primary Health System were $197 million as of June 30, 2016 compared to $163 million as of June 30, 2015, due in part to increased net pension liability.

CHANGES IN NET POSITION

The focus for Erlanger Health System's management team during fiscal year 2016 was to increase the Primary Health System's volumes in a number of key product lines in a flat market, improve relationships with stakeholders, and improve operating efficiencies.

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
(d/b/a Erlanger Health System)

Management's Discussion and Analysis - Continued

Year Ended June 30, 2016

Table 2- Changes in Net Position (in Millions)

	June 30, 2016		*June 30, 2015*	
	Primary Health System	***Discretely Presented Component Units***	***Primary Health System***	***Discretely Presented Component Units***
Net patient revenue	**$ 778**	**$ 11**	$ 670	$ 11
Other revenue	**15**	**22**	16	18
Total revenue	**793**	**33**	686	29
Expenses:				
Salaries	**406**	**14**	333	14
Supplies and other expenses	**174**	**13**	139	10
Purchased services	**160**	**3**	141	3
Depreciation and amortization	**25**	**1**	25	1
Total expenses	**765**	**31**	638	28
Operating income revenues in excess of (less than) expenses	**28**	**2**	48	1
Nonoperating gains	**4**	(1)	1	-
Interest expense and other	**(7)**	-	(12)	-
Operating/capital contributions	**(0)**	-	-	-
Change in net position	**$ 25**	**$ 1**	$ 37	$ 1

Net patient service revenue for the Primary Health System increased from $670 million in fiscal year 2015 to $778 million in fiscal year 2016. Admissions for fiscal year 2016 were 35,758 compared to 33,340 for fiscal year 2015, a 7.3% increase. Observation days decreased from 7,836 for fiscal year 2015 to 7,637 for fiscal year 2016, or by 2.5%. Air ambulance flights increased from 1,994 flights for fiscal 2015 to 2,190 flights for fiscal year 2016, or by 9.8%. Medicare case mix index decreased from 1.88 for fiscal year 2015 to 1.87 for fiscal year 2016. Total surgical inpatients increased from 9,856 for fiscal year 2015 to 10,143 for fiscal 2016, or by 2.9%. Total surgical outpatients for fiscal year 2016 increased by 15.0% over the prior year. Total emergency room visits were 154,907 for fiscal year 2016, a 2.7% increase over fiscal year 2015. Physician practice outpatient visits have increased from 289,578 in fiscal 2015 to 351,875 in fiscal 2016, or by 21.5%. Cardiac cath lab patients were 3,438 for fiscal year 2016, a 20.0% increase over fiscal year 2015.

Salaries for the Primary Health System increased from $333 million in fiscal year 2015 to $406 million in fiscal year 2015. Staffing was in concert with the increased volumes. Paid FTE's per adjusted occupied bed decreased from 4.8 in fiscal year 2015 to 4.7 in fiscal year 2016, however, salary cost for fiscal year 2016 per hour increased by 6.7% over the prior year. A market

adjustment was implemented in July 2015 for bedside nurses. A 3% raise for all other eligible employees was implemented in January 2016.

Supplies and other expenses increased from $139 million for fiscal year 2015 to $174 million in fiscal year 2016. Supplies and drug costs trended with the volume increases. Supplies and drugs per adjusted admission for the Primary Health System increased from $1,573 in fiscal year 2015 to $1,815 in fiscal year 2016 resulting from higher implant costs due to increased surgery volumes. Drug costs increased also due to expansion of the infusion center.

Purchased services increased from $141 million in fiscal year 2015 to $160 million in fiscal year 2016 due in part to an increase in contracted hospitalist fees resulting from increased volumes and increased outside legal fees.

Depreciation and amortization expense was $25 million in fiscal year 2016 and was consistent with the prior year.

Interest expense, including gain (or loss) on mark-to-market of interest rate swaps in 2015, decreased from $12 million in fiscal year 2015 to $7 million in fiscal year 2016 due to capitalized interest expense associated with the expansion of Erlanger East Hospital. The Series 2014 Bonds issued in December 2014 resulted in $71 million in additional debt. The interest rate swaps agreements were terminated in fiscal year 2015.

OUTLOOK

The State of Tennessee continues to review the TennCare program (the State's Medicaid program). For fiscal years 2012 and 2013, the State passed a Hospital Coverage Fee to offset shortfalls in the State's budget for TennCare. The fee has remained intact and TennCare rates were stable in fiscal years 2014 - 2016. There could be possible TennCare rate changes in fiscal year 2017 as a result of rate variation initiatives. CMS has notified the State of their intention to change the methodology of the supplemental pools. The TennCare waiver has been extended through September 30, 2016 while CMS and the State negotiate the new methodology. Out-of-state Medicaid and TennCare changes would affect the Primary Health System's bottom line with TennCare and Medicaid patients representing approximately 23% of the payer mix. Self-pay patients represent approximately 7% of the charge utilization. Healthcare reform and future changes in Medicare regulations could also have an adverse effect on the Primary Health System's future operations since Medicare represents approximately 34% of the payer mix.

During fiscal year 2014, the Primary Health was added as a participant to the Public Hospital Supplemental Payment Pool for public hospitals in Tennessee through a collaborative effort with local Mayors, State Senators and Representatives, Hamilton County Medical Society, Board members, physicians and hospital leadership. The inclusion of the Primary Health System in the

pool netted $18.8 million of additional federal funding for fiscal year 2015 and $18.2 million for fiscal year 2015. The Primary Health System will receive this funding annually as long as the current TennCare waiver is intact. Funding of $20.6 for fiscal year 2017 was received in August 2016.

The Primary Health System recognized Essential Access payments totaling $10.4 million from the State of Tennessee for fiscal year 2016, a decrease of $7.1 million from fiscal year 2015. Disproportionate share payments were not approved by the Federal government for fiscal year 2014 and funds received during 2015 were deferred until 2016 based on management's evaluation. Disproportionate share payments of $15.1 million were recorded in fiscal year 2016. Additionally, the Primary Health System recognized trauma funding of $1.1 million in fiscal years 2016 and 2015. Payments from the State of Tennessee for the fiscal year 2017 are expected to be consistent with the fiscal year 2016. Due to the 1966 Hamilton County Sales Tax Agreement expiring in May 2011, the Hamilton County appropriations to the Primary Health System have been reduced from $3 million to $1.5 million.

The focus of Erlanger Health System's CEO and leadership team for fiscal year 2016 has been top-line, sustainable growth, cost containment and strengthened physician relations. The strategic plans put in place this fiscal year have yielded strong positive results and enabled investment in Erlanger and the community. The health system has infused $71 million from bond sales into major growth initiatives.

Fiscal year 2017 will reflect continued growth based on initiatives completed to date and others in the process of being completed. In particular, the surgery expansion at the main campus is expected to be a strong contributor to health system performance as is the $50 million expansion at Erlanger East, where a full service hospital will be made available for the first time to residents of East Hamilton County. While the response to opening of the emergency department at Erlanger East Hospital over the last several years has been far stronger than originally anticipated, establishing a full service hospital is a different challenge, requiring effective execution on a much broader stage. During fiscal 2017, the Primary Health System will implement the ambulatory module of Epic. The inpatient module of Epic will be implemented in fiscal 2018. A strong team and support cast are in place; however, the complexities of the challenge are magnified as an array of programs and services and providers need to coordinate efforts to execute successfully. Competition and related market place additional challenges and risks to the mix. An effective team is in place to accelerate effective execution of this endeavor.

Audited Combined Financial Statements

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
(d/b/a Erlanger Health System)

Combined Statements of Net Position

	June 30, 2016	
	Primary Health System	*Discretely Presented Component Units*
ASSETS		
CURRENT ASSETS:		
Cash and cash equivalents	$ 90,387,026	$ 3,393,643
Temporary investments	2,743,655	5,450,986
Patient accounts receivable, net	123,074,843	1,775,904
Estimated amounts due from third party payers	8,000,119	-
Due from other governments	254,856	496,216
Inventories	16,027,986	1,258,727
Receivable from Walker County, Georgia	8,705,000	-
Other current assets	19,756,209	1,435,555
TOTAL CURRENT ASSETS	268,949,694	13,811,031
NET PROPERTY, PLANT AND EQUIPMENT	186,065,992	7,992,444
LONG-TERM INVESTMENTS, for working capital	850,871	-
ASSETS LIMITED AS TO USE	157,641,228	-
OTHER ASSETS:		
Prepaid bond insurance	721,060	-
Equity in discretely presented component units	15,592,240	-
Other assets	12,820	509,405
TOTAL OTHER ASSETS	16,326,120	509,405
TOTAL ASSETS	629,833,905	22,312,880
DEFERRED OUTFLOWS OF RESOURCES		
Deferred pension adjustments	13,312,023	-
Deferred amounts from debt refunding	1,580,780	-
TOTAL DEFERRED OUTFLOWS OF RESOURCES	14,892,803	-
COMBINED ASSETS AND DEFERRED OUTFLOWS OF RESOURCES	$ 644,726,708	$ 22,312,880

See notes to combined financial statements.

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
(d/b/a Erlanger Health System)

Combined Statements of Net Position - Continued

	June 30, 2016	
	Primary Health System	*Discretely Presented Component Units*
LIABILITIES		
CURRENT LIABILITIES:		
Accounts payable and accrued expenses	$ 67,607,554	$ 1,470,211
Accrued salaries and related liabilities	28,370,165	1,161,977
Due to other governments	496,216	254,856
Current portion of long-term debt and capital leases	4,726,161	2,513,748
Other current liabilities	3,727,483	297,008
TOTAL CURRENT LIABILITIES	104,927,579	5,697,800
LONG-TERM DEBT AND CAPITAL LEASE OBLIGATIONS	208,003,442	3,606
NET PENSION LIABILITY	66,838,386	-
OTHER LONG-TERM LIABILITIES	25,532,353	310,791
TOTAL LIABILITIES	405,301,760	6,012,197
DEFERRED INFLOWS OF RESOURCES		
Deferred pension adjustments	511,392	-
Deferred gain from sale-leaseback	3,006,213	-
TOTAL DEFERRED INFLOWS OF RESOURCES	3,517,605	-
NET POSITION:		
Unrestricted	215,326,506	10,776,642
Net investment in capital assets	17,320,388	5,524,041
Restricted expendable:		
Health plan trust	1,633,882	-
Donor restricted	1,626,567	-
TOTAL NET POSITION	235,907,343	16,300,683
COMBINED LIABILITES, DEFERRED OUTFLOWS OF RESOURCES AND NET POSITION	$ 644,726,708	$ 22,312,880

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
(d/b/a Erlanger Health System)

Combined Statements of Changes in Net Position

	Year Ended June 30, 2016	
	Primary Health System	*Discretely Presented Component Units*
OPERATING REVENUE:		
Charges for services:		
Net patient service revenue	$ 778,002,400	$ 11,463,849
Other revenue	14,980,073	21,808,250
TOTAL OPERATING REVENUE	792,982,473	33,272,099
OPERATING EXPENSES:		
Salaries, wages and benefits	406,325,308	14,117,579
Supplies and other expenses	170,844,193	12,861,808
Purchased services	159,746,508	2,761,900
Insurance and taxes	3,195,380	343,725
Depreciation	24,912,090	1,240,327
TOTAL OPERATING EXPENSES	765,023,479	31,325,339
OPERATING INCOME	27,958,994	1,946,760
NONOPERATING REVENUE (EXPENSES):		
Gain on disposal of assets	877,611	5,592
Interest and investment income, net of fees	1,998,866	81,385
Net gain from discretely presented component units	1,114,224	-
Interest expense	(6,546,731)	(126,948)
Provision for income taxes	-	(553,540)
NET NONOPERATING REVENUE (EXPENSES)	(2,556,030)	(593,511)
INCOME BEFORE CONTRIBUTIONS	25,402,964	1,353,249
Operating distributions	(429,104)	(178,000)
Capital contributions	221,306	-
CHANGE IN NET POSITION	25,195,166	1,175,249
NET POSITION AT BEGINNING OF YEAR	210,712,177	15,125,434
NET POSITION AT END OF YEAR	$ 235,907,343	$ 16,300,683

See notes to combined financial statements.

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
(d/b/a Erlanger Health System)

Combined Statement of Cash Flows

Primary Health System	*Year Ended June 30, 2016*
CASH FLOWS FROM OPERATING ACTIVITIES:	
Receipts from third-party payers and patients	$ 748,652,990
Payments to vendors and others for supplies, purchased services, and other expenses	(324,781,774)
Payments to and on behalf of employees	(403,108,228)
Other receipts	16,894,391
NET CASH PROVIDED BY OPERATING ACTIVITIES	37,657,379
CASH FLOWS FROM NONCAPITAL FINANCING ACTIVITIES:	
Contributions to other organizations	(429,104)
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES:	
Acquisition and construction of capital assets, net	(65,714,585)
Proceeds from sale of assets	749,604
Principal paid on bonds, capital lease obligations and other	(4,863,355)
Interest payments on long-term debt	(9,582,409)
Capital contributions	221,306
NET CASH USED IN CAPITAL AND RELATED FINANCING ACTIVITIES	(79,189,439)
CASH FLOWS FROM INVESTING ACTIVITIES:	
Interest, dividends, and net realized gains (losses) on investments	1,998,866
Change in temporary and long-term investments for working capital	(11,389)
Payments received on note receivable	8,840,000
Net cash transferred from assets limited as to use	28,878,211
NET CASHPROVIDED BY INVESTING ACTIVITIES	39,705,688
INCREASE IN CASH AND CASH EQUIVALENTS	(2,255,476)
CASH AND CASH EQUIVALENTS AT BEGINNING OF YEAR	92,642,502
CASH AND CASH EQUIVALENTS AT END OF YEAR	$ 90,387,026

See notes to combined financial statements.

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
(d/b/a Erlanger Health System)

Combined Statement of Cash Flows - Continued

Primary Health System	*Year Ended June 30, 2016*
RECONCILIATION OF OPERATING INCOME TO NET CASH PROVIDED BY OPERATING ACTIVITIES:	
Operating income	$ 27,958,994
Adjustments to reconcile operating income to net cash provided by operating activities:	
Depreciation	24,912,090
Pension adjustments	5,821,326
Gain on disposal of assets	(464,756)
Changes in assets and liabilities:	
Patient accounts receivable, net	(29,287,384)
Estimated amounts due from third party payers, net	(2,600,248)
Inventories and other assets	(10,909,394)
Accounts payable and accrued expenses	17,139,289
Accrued salaries and related liabilities	9,038,406
Other current and long-term liabilities	(3,950,944)
NET CASH PROVIDED BY OPERATING ACTIVITIES	$ 37,657,379

See notes to combined financial statements.

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
(d/b/a Erlanger Health System)

Notes to Combined Financial Statements

Year Ended June 30, 2016

NOTE A--SIGNIFICANT ACCOUNTING POLICIES

Reporting Entity: The Chattanooga-Hamilton County Hospital Authority d/b/a Erlanger Health System (the Primary Health System) was created by a private act passed by the General Assembly of the State of Tennessee on March 11, 1976, and adopted by a majority of the qualified voters of Hamilton County, Tennessee on August 5, 1976. The Chattanooga-Hamilton County Hospital Authority consists of the Primary Health System and its aggregate discretely presented component units as disclosed below.

The Primary Health System provides comprehensive healthcare services throughout Hamilton and Bledsoe counties, as well as outlying areas in southeastern Tennessee and north Georgia. These services are provided primarily through the hospital and other facilities located on the Baroness campus of Erlanger Medical Center. The Primary Health System also operates other hospitals and clinics throughout the area. The Primary Health System is considered the primary governmental unit for financial reporting purposes. As required by accounting principles generally accepted in the United States of America, these combined financial statements present the Primary Health System and its component units. The component units discussed below are included in the Primary Health System's reporting entity because of the significance of their operational or financial relationships with the Primary Health System.

The primary mission of the Primary Health System and its component units is to provide healthcare services to the citizens of Chattanooga, Hamilton County and the surrounding area. Only those activities directly associated with this purpose are considered to be operating activities. Other activities that result in gains or losses unrelated to the Primary Health System's primary mission are considered to be nonoperating.

Erlanger Health Plan Trust, ContinuCare HealthServices, Inc., Cyberknife of Chattanooga, LLC, and UT-Erlanger Medical Group, Inc. are legally separate organizations which the Primary Health System has determined are component units of the Primary Health System.

Blended Component Units: The financial statements of Erlanger Health Plan Trust include assets limited as to use totaling $1,633,882 as of June 30, 2016 and net investment gain totaling $10,466 for the year ended June 30, 2016 that are blended in the combined financial statements of the Primary Health System. The board of the Erlanger Health Plan Trust is substantially the same as that of the Primary Health System and the Primary Health System has operational responsibility.

Discretely Presented Component Units: The discretely presented component units' column in the combined financial statements includes the financial data of the Primary Health System's other component units. They are reported in a separate column to emphasize that they are legally

separate from the Primary Health System. See the combined, condensed financial information in Note O.

1. ContinuCare HealthServices, Inc. and subsidiary (ContinuCare) provide health and supportive services to individuals in their homes in the Hamilton County and north Georgia areas. ContinuCare also provides retail pharmacy goods and services at four locations in Hamilton County. The Primary Health System owns 100% of the stock of ContinuCare. Separately audited financial statements for ContinuCare HealthServices, Inc. may be obtained by mailing a request to 1501 Riverside Drive, Suite 140, Chattanooga, Tennessee 37406.

2. Cyberknife of Chattanooga, LLC (Cyberknife) provides radiation therapy services, specifically robotic stereotactic radiosurgical services, through the use of a cyberknife stereotactic radiosurgery system on the Primary Health System's campus. The Primary Health System owns 51% of Cyberknife's outstanding membership units and Cyberknife is fiscally dependent on the Primary Health System.

   A condition of admission as a Member of Cyberknife, is to deliver limited guaranties, guaranteeing pro-rata repayment of indebtedness of Cyberknife incurred to finance its equipment costs and its working capital needs. As of June 30, 2016, total debt outstanding was $2,492,581 with payments due through 2017. Management believes that the Primary Health System will not be required to make any payments related to the guarantee of this indebtedness.

3. UT-Erlanger Medical Group, Inc. (the Medical Group) was formed on June 30, 2011 and will provide professional healthcare and related services to the public through employed and contracted licensed physicians and other supporting healthcare providers. The Medical Group has no members; however, the Primary Health System may access the Medical Group's services. The Primary Health System is not entitled to any potential earnings of the Medical Group except for compensation for services rendered to the Medical group on its behalf. However, based upon the significance of the Medical Group's potential operation to the Primary Health System, management believes its exclusion would be misleading and as such, includes the Medical Group as a component unit. The Medical Group is currently not active.

Erlanger Health System Foundations (the Foundation): The Foundation assists the Primary Health System to promote and develop charitable and educational opportunities as they relate to healthcare services provided by the Primary Health System. The Primary Health System is not financially accountable for the Foundation and as a result, the Foundation has not been included in the combined financial statements.

No contributions from the Foundation were recognized as contribution revenue by the Primary Health System for the year ended June 30, 2016. The Primary Health System provided support to the Foundation of $662,000 in 2016.

Use of Estimates: The preparation of the combined financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities as of the date of the combined financial statements and the reported amounts of revenue and expenses during the reporting period. Actual results could differ from those estimates.

Enterprise Fund Accounting: The Primary Health System and its blended component units utilize the enterprise fund method of accounting whereby revenue and expenses are recognized on the accrual basis using the economic resources measurement focus.

Recently Issued or Effective Accounting Pronouncements: In February 2015, the Governmental Accounting Standards Board (GASB) issued Statement No. 72, *Fair Value Measurement and Application.* Statement No. 72 defines fair value and describes how fair value should be measured, what assets and liabilities should be measured at fair value, and what information about fair value should be disclosed in the notes to the financial statements. This statement was adopted by the Primary Health System during 2016 and included the required additional disclosures in the combined financial statements.

Net Patient Service Revenue/Receivables: Net patient service revenue is reported on the accrual basis in the period in which services are provided at rates which reflect the amount expected to be collected. Net patient service revenue includes amounts estimated by management to be reimbursable by third-party payer programs under payment formulas in effect. Net patient revenue also includes an estimated provision for bad debts based upon management's evaluation of collectability based upon the age of the receivables and other criteria, such as payer classification and management's assumptions about conditions it expects to exist and courses of action it expects to take. The Primary Health System's policies do not require collateral or other security for accounts receivable, although the Primary Health System routinely accepts assignment or is otherwise entitled to receive patient benefits payable under health insurance programs, plans or policies. Supplemental payments from the State of Tennessee are recognized when determinable over the period to which they pertain (see Note B).

Charity Care: The Primary Health System accepts patients regardless of their ability to pay. A patient is classified as a charity patient by reference to certain policies established by the County Auditor with regard to the Hamilton County indigent program or by the Primary Health System for other patients. Essentially, these policies define charity services as those services for which minimal payment is anticipated. In assessing a patient's inability to pay, the County and the

Primary Health System utilize the generally recognized poverty income levels, but also include certain cases where incurred charges are significant when compared to the income of the patient. These charges are not included in net patient service revenue.

Cash Equivalents: The Primary Health System considers all highly liquid investments with maturities of three months or less when purchased, excluding amounts whose use is limited by board designation, held by trustees under indenture agreement, or otherwise restricted as to use, to be cash equivalents.

Inventories: Inventories consist principally of medical and surgical supplies, general store supplies, and pharmacy items and are stated at lower of cost (first-in, first-out) or fair market value.

Investments: The Primary Health System's investments (including assets limited as to use) are reported at fair market value. Assets limited as to use include funds designated by the Board, funds held by trustees under trust indentures, and funds restricted by donors or grantors for specific purposes. The Primary Health System considers those investments with maturities of more than three months when purchased, maturing in more than one year and whose use is not limited by board designation, held by trustees under indenture agreement, or otherwise restricted as to use, to be long-term investments.

Temporary Investments: The Primary Health System considers all highly liquid investments with maturities of less than three months when purchased and maturing in less than one year, excluding amounts whose use is limited by board designation, held by trustees under indenture agreement, or otherwise restricted as to use, to be temporary investments.

Net Property, Plant and Equipment: Property, plant and equipment is recorded on the basis of cost. Donated assets are recorded at their fair market value at the date of donation. Leases that are substantially installment purchases of property are recorded as assets and amortized over the lessor of their estimated useful lives or the lease term which range from three to twenty years; related amortization is included in depreciation expense. Depreciation expense is computed over estimated service lives of the respective classes of assets using the straight-line method. The Primary Health System has established a capitalization threshold for property, plant and equipment of $2,500 except for computer equipment, which has a threshold of $1,000. Interest expense and interest income on borrowed funds related to construction projects are capitalized during the construction period, if material. Costs of maintenance and repairs are charged to expense as incurred.

The Primary Health System reviews the carrying value of capital assets if facts and circumstances indicate that recoverability may be impaired. A capital asset is considered impaired when its service utility has declined significantly and unexpectedly. The Primary

Health System did not experience any prominent events or changes in circumstances affecting capital assets which would require determination as to whether impairment of a capital asset has occurred during the year ended June 30, 2016.

Prepaid Bond Insurance: Financing costs related to insurance associated with bond issues are being amortized over the terms of the respective debt issues by the effective interest method.

Compensated Absences: The Primary Health System recognizes an expense and accrues a liability for employees' paid annual leave and short-term disability in the period in which the employees' right to such compensated absences is earned. Liabilities expected to be paid within one year are included as accrued salaries and related liabilities in the accompanying combined statements of net position.

Pensions: Pension amounts (net pension liability, deferred outflows of resources and deferred inflows of resources related to pensions, and pension expense, fiduciary net position of the Primary Health System's pension plan and additions to or deductions from the plan's fiduciary net position) have been determined on the same basis as they are reported by the Plan. For this purpose, benefit payments are recognized when due and payable in accordance with the benefit terms. Investments are reported at fair value

Income Taxes: The Primary Health System is exempt from income taxes under Section 501(a) as an organization described in Section 501(c)(3) of the Internal Revenue Code (IRC). In addition, it qualifies for exemption from federal income taxes pursuant to IRC Section 115 as an instrumentality of the State of Tennessee. Therefore, no provision for income taxes has been recognized in the accompanying combined financial statements for the Primary Health System.

As a for-profit entity, ContinuCare is subject to state and federal income taxes. ContinuCare HealthServices, Inc. and its subsidiary file consolidated federal income tax returns separately from the Primary Health System. At June 30, 2016, ContinuCare had no significant uncertain tax positions. Tax returns for the years ended June 30, 2013 through 2016 are subject to examination by taxing authorities.

As a limited liability corporation, Cyberknife, is subject to State of Tennessee income taxes. At June 30, 2016 Cyberknife had no significant uncertain tax positions. Tax returns for the years ended June 30, 2013 through 2016 are subject to examination by taxing authorities.

Contributed Resources: Resources restricted by donors for specific operating purposes are held as restricted funds and are recognized as operating or capital contributions in the accompanying combined financial statements. When expended for the intended purpose, they are reported as operating distributions and are recognized as other operating revenue. When an expense is incurred for purposes for which both restricted and unrestricted resources are available, restricted

resources are used first. Contributed resources consist of amounts restricted by donors for specific purposes. Fundraising expenses are netted against contributions recognized.

Net Position: The net position of the Primary Health System is classified into three components. *Net investment in capital assets* consists of capital and other assets net of accumulated depreciation and reduced by the current balances of any outstanding borrowings used to finance the purchase or construction of those assets. The *restricted expendable* net position consists of assets that must be used for a particular purpose that are either externally imposed by creditors, grantors, contributors or laws or regulations of other governments or imposed by law through constitutional provisions or enabling legislation. *The unrestricted net position* is remaining assets that do not meet the definition of *net investment in capital assets* or *restricted expendable.*

Fair Value of Financial Instruments: The carrying amounts reported in the combined statements of net position approximate fair value except as described below.

The carrying value of long-term debt and capital lease obligations (including the current portion) was $212,729,603 as of June 30, 2016. The estimated fair value of long-term debt and capital lease obligations (including current portion) was $230,778,250 at June 30, 2016. The fair value of long-term debt related to fixed interest long-term debt and capital lease obligations was estimated using discounted cash flows, based on the Primary Health System's incremental borrowing rates or from quotes obtained from investment advisors. The fair value of long-term debt related to variable rate debt approximates its carrying value.

Subsequent Events: The Primary Health System evaluated all events or transactions that occurred after June 30, 2016 through September 12, 2016, the date the combined financial statements were available to be issued and noted no events that required recognition or disclosure in the combined financial statements except as disclosed in Note N.

NOTE B--NET PATIENT SERVICE REVENUE

A reconciliation of the amount of services provided to patients at established rates by the Primary Health System to net patient service revenue as presented in the combined statements of revenue, expenses and changes in net position for the year ended June 30, 2016 is as follows:

	Primary Health System
Inpatient service charges	$1,410,727,138
Outpatient service charges	1,148,094,992
Gross patient service charges	2,558,822,130

	Primary Health System
Less: Contractual adjustments and other discounts	1,575,527,537
Charity care	119,836,064
Provision for bad debts	85,456,129
	1,780,819,730
Net patient service revenue	$ 778,002,400

Charity Care and Community Benefit: The Private Act of the State of Tennessee establishing the Primary Health System obligates the Primary Health System to make its facilities and patient care programs available to the indigent residents of Hamilton County to the extent of funds appropriated by Hamilton County and adjusted operating profits, as defined. The annual appropriation from Hamilton County totaled $1,500,000 for fiscal year 2016. Total charity care charges for services provided to the certified indigent residents of Hamilton County (net of the appropriation) were approximately $8,319,000 for the year ended June 30, 2016 for the Primary Health System.

In addition to charity care provided to specific patients within the hospital setting, the Primary Health System also provides unreimbursed services to the community which includes free and low cost health screenings. The Primary Health System also hosts health fairs and helps sponsor many other events that are free to the public and are spread throughout the year in various community locations.

The Primary Health System's Community Relations department includes HealthLink Plus, a free adult membership program with over 8,000 members in the Chattanooga Statistical Metropolitan Service Area. The Community Relations department hosts several free community events throughout the year utilizing the services of physicians, nurses, volunteers, educators, registered dietitians, social workers, secretaries and management personnel of the Primary Health System.

The Primary Health System's consumer call center, Erlanger HealthLink (423-778-LINK) is a free call center staffed by RN's to answer health questions, offer free physician referrals and to register participants in the programs offered by Community Relations, Women's & Infant Services and other departments and divisions of the Primary Health System.

Uncompensated Care Costs: The following table summarizes the estimated total uncompensated care costs (based on the ratio of total operating revenue and expenses) provided by Erlanger Medical Center as defined by the State of Tennessee for the year ended June 30, 2016:

Uncompensated cost of TennCare/Medicaid	$	30,965,861
Traditional charity uncompensated costs		35,185,333
Bad debt cost		24,563,521
Total estimated uncompensated care costs	$	90,714,715

The uncompensated cost of TennCare/Medicaid is estimated by taking the estimated cost of providing care to the TennCare/Medicaid patients less payments from the TennCare and Medicaid programs. The payments exclude revenues from essential access and other, one-time supplemental payments from TennCare of approximately $10,371,000 for the year ended June 30, 2016 and such payments are not guaranteed for future periods.

Revenue from Significant Payers: Gross patient service charges related to the Medicare program accounted for approximately 30.1% of the Primary Health System's patient service charges for the year ended June 30, 2016. Gross patient service charges related to the TennCare/Medicaid programs accounted for approximately 23.0% of the Primary Health System's patient service charges for the year ending June 30, 2016. TennCare typically reimburses providers at an amount less than their cost of providing services to TennCare patients. At June 30, 2016, the Primary Health System has a credit concentration related to the Medicare and TennCare programs.

During 2016, the Primary Health System recognized revenue from these programs related to trauma fund payments of approximately $1,080,000. Further, during 2016, the Primary Health System recognized disproportionate share payments of approximately $15,130,000 which includes approximately $5,085,000 received in 2015. Recognition of the 2015 payment was deferred until 2016 and is based on management's continued evaluation. Such amounts are subject to audit and potential recoupments although management believes it has meritorious defenses against any such recoupments. Future distributions under these programs are not guaranteed. In 2016 the Primary Health System also received and recognized a net payment of $18,207,056 from the Public Hospital Supplemental Payment Pool. Such amounts are expected to be received as long as the current TennCare waiver is intact.

Laws and regulations governing the Medicare and TennCare/Medicaid programs are complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates, as they relate to revenue recognized from these programs, will change by a material amount in the near term. The estimated reimbursement amounts are adjusted in subsequent periods as cost reports are prepared and filed and as final settlements are determined. Final determination of amounts earned under prospective payment and cost reimbursement activities is subject to review by appropriate governmental authorities or their agents. Management believes that adequate provisions have been made for adjustments that may result from final determination of amounts earned under Medicare and Medicaid programs. The effect of prior year cost report settlements, or changes in estimates, increased net patient service revenue by approximately $3,190,000 in 2016.

The Primary Health System has also entered into reimbursement agreements with certain commercial insurance companies, health maintenance organizations and preferred provider organizations. The basis for reimbursement under these agreements includes prospectively determined rates, per diems and discounts from established charges.

NOTE C--CASH AND CASH EQUIVALENTS

Cash and cash equivalents reported on the combined statements of net position include cash on hand and deposits with financial institutions including demand deposits and certificates of deposit, as well as, money market accounts that are held in investment accounts and meet the definition of a cash equivalent.

Cash and cash equivalents consist of the following:

	Primary Health System
Demand deposits	$ 90,375,572
Cash on hand	11,454
	$ 90,387,026

Bank balances consist of the following:

	Primary Health System
Insured (FDIC)	$ 535,615
Collateralized under the State of Tennessee Bank Collateral Pool	91,499,430
	$ 92,035,045

The Primary Health System's deposits would be exposed to custodial credit risk if they are not covered by depository insurance and the deposits are uncollateralized or are collateralized with securities held by the pledging financial institution's trust department or agent but not in the depositor government's name. The risk is that, in the event of the failure of a depository financial institution, the Primary Health System will not be able to recover deposits or will not be able to recover collateral securities that are in the possession of an outside party.

NOTE D--DISAGGREGATION OF RECEIVABLE AND PAYABLE BALANCES

Patient Accounts Receivable, Net: Patient accounts receivable and related allowances are as follows:

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
(d/b/a Erlanger Health System)

Notes to Combined Financial Statements - Continued

Year Ended June 30, 2016

	Primary Health System
Gross patient accounts receivable	$ 471,635,785
Estimated allowances for contractual adjustments and uncollectible accounts	(348,560,942)
Net patient accounts receivable	$ 123,074,843

Other Current Assets: Other current assets consist of the following:

	Primary Health System
Prepaid expenses	$ 5,165,306
Other receivables	14,590,903
Total other current assets	$ 19,756,209

Accounts Payable and Accrued Expenses: Accounts payable and accrued expenses consist of the following:

	Primary Health System
Due to vendors	$ 60,368,930
Other	7,238,624
Total accounts payable and accrued expenses	$ 67,607,554

Other Long-Term Liabilities: Other long-term liabilities, and the related activity, consist of the following:

	Balance at Beginning of Year	*Unearned Revenue Recognized*	*Payments /Other*	*Balance at End of Year*
Compensated absences	$ 10,638,408	$ -	$ 6,392,217	$ 17,030,625
Medical malpractice	4,934,900	-	37,500	4,972,400
Job injury program	1,253,139	-	-	1,253,139
Deferred revenue	2,580,036	(393,607)	-	2,186,429
Other	89,760	-	-	89,760
Total other long-term liabilities	$ 19,496,243	$ (393,607)	$ 6,429,717	$ 25,532,353

NOTE E--NET PROPERTY, PLANT AND EQUIPMENT

Net property, plant and equipment activity for the Primary Health System consisted of the following:

	Balance at June 30, 2015	*Additions*	*Reductions/ Transfers*	*Balance at June 30, 2016*
Capital assets:				
Land and improvements	$ 20,992,928	$ 664,758	$ (88,400)	$ 21,569,286
Buildings	229,751,179	24,673	3,936,780	233,712,632
Equipment	387,378,986	3,634,501	19,121,352	410,134,839
	638,123,093	4,323,932	22,969,732	665,416,757
Accumulated depreciation :				
Land and improvements	(8,780,699)	(287,365)	242,294	(8,825,770)
Buildings	(179,046,470)	(6,270,262)	54,509	(185,262,223)
Equipment	(319,102,026)	(18,354,463)	2,530,956	(334,925,533)
	(506,929,195)	(24,912,090)	2,827,759	(529,013,526)
Capital assets net of accumulated depreciation	131,193,898	(20,588,158)	25,797,491	136,403,231
Construction in progress	10,932,463	64,399,785	(25,669,487)	49,662,761
	$ 142,126,361	$ 43,811,627	$ 128,004	$ 186,065,992

Construction in progress at June 30, 2016 consists of various projects for additions and renovations to the Primary Health System's facilities and computer systems. The estimated cost to complete construction projects is approximately $42,000,000. During 2016, the Primary Health System capitalized interest expense of approximately $3,300,000 on construction projects, net of interest income of approximately $300,000 earned on construction funds.

NOTE F--INVESTMENTS AND ASSETS LIMITED AS TO USE

The Primary Health System invests primarily in United States government and agency obligations, municipal bonds and short-term money market investments that are in accordance with the Primary Health System's investment policy. The carrying and estimated fair values for long-term investments, and assets limited as to use, by type are as follows:

	Primary Health System
U.S. Treasury notes	$ 39,303,272
U.S. Government agency obligations	83,978,073
Municipal bonds	23,177,684
Corporate bonds	526,965
Bond mutual funds	5,175,552
Cash equivalents	6,330,553
Total investments and assets limited as to use	$ 158,492,099

Assets limited as to use are designated for the following purposes:

	Primary Health System
Capital investment funds	$ 107,430,593
Under bond indentures - held by trustees	
Debt service reserve fund	6,196,128
Construction fund	37,066,811
Self-insurance trust	5,313,814
Health plan trust	1,633,882
	$ 157,641,228

Assets limited as to use for capital investment are to be used for the replacement of property and equipment or for any other purposes so designated. The debt service reserve fund is to be used only to make up any deficiencies in other funds related to the Hospital Revenue and Refunding Bonds Series 2004. The construction fund may be used for various construction and renovation projects related to the Series 2014 bonds.

The Primary Health System's investment policy specifies the types of investments which can be included in board-designated assets limited as to use, as well as collateral or other security requirements. The investment policy also specifies the maximum maturity of the portfolio of board-designated assets. Assets limited as to use and held by trustees are invested as permitted by the bond indenture.

Custodial Credit Risk: The Primary Health System's investment securities are exposed to custodial credit risk if the securities are uninsured, are not registered in the name of the Primary Health System, and are held by either the counterparty or the counterparty's trust department or agent but not in the Primary Health System's name. The risk is that, in the event of the failure of

the counterparty to a transaction, the Primary Health System will not be able to recover the value of the investment or collateral securities that are in the possession of an outside party. Substantially all of the Primary Health System's investments, including assets limited as to use, are uninsured or unregistered. Securities are held by the counterparty, or by its trust department or agent, in the Primary Health System's name.

Concentration of Credit Risk: This is the risk associated with the amount of investments the Primary Health System has with any one issuer that exceeds 5% or more of its total investments. Investments issued or explicitly guaranteed by the U.S. Government and investments in mutual funds, external investment pools, and other pooled investments are excluded from this requirement. The Primary Health System's investment policy does not restrict the amount that may be held for any single issuer. At June 30, 2016, none of the Primary Health System's investments with any one issuer exceed 5% of its total investments except certain U.S. Government agency obligations.

Credit Risk: This is the risk that an issuer or other counterparty to an investment will not fulfill its obligations. The Primary Health System's investment policy provides guidelines for its fund managers and lists specific allowable investments. The credit risk profile of the Primary Health System's investments, including assets limited as to use (excluding U.S. Government securities), as of June 30, 2016, is as follows:

		Rating				
Investment Type	*Total*	*AAA*	*AA*	*A*	*BBB*	*N/A*
U.S. Government agency obligations	$ 83,978,073	$ 82,371,518	$ 1,606,555	$ -	$ -	$ -
Municipal bonds	23,177,684	11,246,929	11,930,755	-	-	-
Corporate bonds	526,965	-	-	526,965	-	-
Bond mutual funds	5,175,552	5,175,552	-	-	-	-
Cash equivalents	6,330,553	-	-	-	-	6,330,553
Total investments	$ 119,188,827	$ 98,793,999	$ 13,537,310	$ 526,965	$ -	$ 6,330,553

Interest Rate Risk: This is the risk that changes in interest rates will adversely affect the fair value of an investment. The Primary Health System's investment policy authorizes a strategic asset allocation that is designed to provide an optimal return over the Primary Health System's investment horizon and within specified risk tolerance and cash requirements. The distribution of the Primary Health System's investments, including assets limited as to use, by maturity as of June 30, 2016, is as follows:

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
(d/b/a Erlanger Health System)

Notes to Combined Financial Statements - Continued

Year Ended June 30, 2016

		Remaining Maturity				
Investment Type	*Total*	*12 months or less*	*13-24 Months*	*25-60 Months*	*Over 60 Months*	*N/A*
U.S. Treasury notes	$ 39,303,272	$ 2,183,788	$ 7,570,078	$ 29,549,406	$ -	$ -
U.S. Government agency obligations	83,978,073	26,799,542	3,321,322	1,821,198	52,036,011	-
Municipal bonds	23,177,684	16,236,876	4,663,614	2,277,194	-	-
Corporate bonds	526,965	526,965	-	-	-	-
Bond mutual funds	5,175,552	-	-	-	-	5,175,552
Cash equivalents	6,330,553	6,330,553	-	-	-	-
Total investments	$ 158,492,099	$ 52,077,724	$ 15,555,014	$ 33,647,798	$ 52,036,011	$ 5,175,552

NOTE G--LONG-TERM DEBT

Long-term debt at June 30, 2016 consists of the following:

Revenue and Refunding Bonds, Series 2014A, including bond premium of $8,220,163	$ 158,140,163
Revenue and Refunding Bonds, Series 2004, net of bond discount of $306,042 and including bond issue premium of $649,729	36,183,687
Total bonds payable	194,323,850
2014B Note payable	12,000,000
Other loans	188,397
Capital leases - Note L	6,217,356
	212,729,603
Less: current portion	(4,726,161)
	$ 208,003,442

On December 1, 2014, the Primary Health System issued $149,920,000 Series 2014A bonds for the purpose of advance refunding $20,615,000 of the outstanding Series 2004 bonds (described below), $30,300,000 of the outstanding Series 2000 bonds, $17,375,000 of the Series 1998A bonds, and $27,465,000 of the outstanding Series 1997A bonds. The Primary Health System also utilized the proceeds to pay certain issuance costs and deposited a portion of the bond proceeds in the amount of $71,000,000 into a construction fund. The advance refunding of the of the Series 2004 bonds, Series 1998A bonds, and 1997A bonds resulted in a loss of $1,116,755 that is reported as a deferred outflow of resources and will be amortized over the term of the Series 2014A bonds.

The Series 2014A bonds consist of series bonds maturing annually beginning October 1, 2016 through 2034 and term bonds maturing on October 1, 2039 and 2044. The term bonds are

subject to mandatory sinking fund redemption beginning October 1, 2035. The Series 2014A bonds are also subject to redemption by the Primary Health System at any interest payment date at a redemption price equal to the principal amount plus accrued interest.

Interest rates for the Series 2014A bonds are as follows:

Series bonds	3.0% to 5.0%
Term bonds	4.125% to 5.0%

In conjunction with the issuance of the Series 2014A bonds, the Primary Health Systems issued a $12,000,000 note payable (2014B note) through a financial institution to advance refund the remaining $11,775,000 of outstanding Series 1997A bonds and pay issuance costs. Principal payments of $100,000 are due annually beginning October 1, 2018 until the maturity date of October 1, 2021. The 2014B note bears interest, payable monthly, at a variable rate equal to the 1-month London Interbank Offered Rate plus a margin ranging from .73% to 2.25% based on the debt rating of the Primary Health System. The applicable interest rate at June 30, 2016 was 1.46%.

On January 1, 2004, the Primary Health System issued $85,000,000 insured Series 2004 bonds for the purpose of refunding $80,925,000 of the total outstanding Series 1993 bonds. The Primary Health System also utilized the proceeds to pay certain issuance costs and establish a debt service fund. The outstanding Series 2004 bonds mature annually on October 1 through 2022 in varying amounts. The Series 2004 bonds maturing after October 1, 2019 may be redeemed by the Primary Health System after October 1, 2019 at a redemption price equal to the principal amount plus accrued interest. Interest rates for the outstanding Series 2004 bonds range from 4.0% to 5.0%.

During 2015, a portion of the Series 2004 bonds totaling $20,615,000 were defeased with the issuance of the Series 2014A bonds proceeds through the deposit of funds into an irrevocable escrow account in amounts sufficient to pay the principal and interest when due. A portion of the defeased Series 2004 bonds totaling $9,460,000 has been redeemed. The escrow balance for payment of the remaining principal and interest totaled $12,170,595 at June 30, 2016.

The Series 2014A bonds, Series 2004 bonds and 2014B note were issued on parity, with respect to collateral, and are also secured by a mortgage on a portion of the Primary Health System's main campus. The trust indentures and related documents underlying the bonds contain certain covenants and restrictions. As of June 30, 2016, management believes the Primary Health System is in compliance with all such covenants.

Long-term debt activity for the Primary Health System for the year ended June 30, 2016 consisted of the following:

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
(d/b/a Erlanger Health System)

Notes to Combined Financial Statements - Continued

Year Ended June 30, 2016

	Balance at June 30, 2015	*Additions/ Amortizations*	*Reductions/ Accretions*	*Balance at June 30, 2016*
Bonds Payable				
Series 2014	$ 158,431,142	$ -	$ 290,979	$ 158,140,163
Series 2004	40,429,666	68,637	4,314,616	36,183,687
Total bonds payable	198,860,808	68,637	4,605,595	194,323,850
2014B Note payable	12,000,000	-	-	12,000,000
Other loans	644,749	-	456,352	188,397
Capital leases	6,379,360	-	162,004	6,217,356
Total long-term debt	$ 217,884,917	$ 68,637	$ 5,223,951	$ 212,729,603

The Primary Health System's scheduled principal and interest payments (estimated for variable rate debt based on rates at June 30, 2016) on bonds payable and other long-term debt (excluding capital leases) are as follows:

Year Ending June 30,	*Principal*	*Interest*	*Total*
2017	$ 4,643,397	$ 9,067,848	$ 13,711,245
2018	4,575,000	8,874,446	13,449,446
2019	5,060,000	8,654,716	13,714,716
2020	5,295,000	8,414,249	13,709,249
2021	5,540,000	8,162,454	13,702,454
2022-2026	25,645,000	37,160,231	62,805,231
2027-2031	27,005,000	32,460,701	59,465,701
2032-2036	34,305,000	25,038,116	59,343,116
2037-2041	43,215,000	15,958,313	59,173,313
2042-2045	42,665,000	4,396,875	47,061,875
TOTAL	$ 197,948,397	$ 158,187,949	$ 356,136,346

NOTE H--PENSION PLAN

Plan Description: The Primary Health System sponsors the Chattanooga-Hamilton County Hospital Authority Pension Retirement Plan & Trust (the Plan), a single-employer, non-contributory defined benefit pension plan covering employees meeting certain age and service requirements.

The Primary Health System has the right to amend, in whole or in part, any or all of the provisions of the Plan. Effective July 1, 2009, the Plan was amended to be closed to new

employees or rehires, and to further clarify the maximum years of service to be 30. During June 2014, the Plan was amended to freeze the accrual of additional benefits.

Benefits Provided: In addition to normal retirement benefits, the Plan also provides for early retirement, disability and death benefits. Retirement benefits are calculated as a percent of the employee's average monthly salary for the last 10 calendar years (prior to June 2014) times the employee's years of service. Employees earn full retirement benefits after 30 years of service. Early retirement benefits are available once an employee has reached age 55 and 10 years of service at a reduced rate based on age. Disability retirement benefits are available after 3 years of credited service, determined in the same manner as retirement benefits and are payable at the normal retirement date. Death benefits equal the actuarial equivalent value of the employee's vested accrued benefit as of the date of death. An employee who terminates service for other reasons after three years of credited service will receive retirement benefits at the normal retirement date.

Employees Covered: At July 1, 2016, the following employees were included in the Plan:

Active employees	1,916
Inactive employees with deferred benefits	1,386
Inactive employees currently receiving benefits	173
	3,475

Contributions: The Primary Health System has no legal or Plan requirements to fund the Plan and funds the Plan as contributions are approved by the Board of Trustees based on an actuarially determined rate recommended by an independent actuary. The actuarially determined rate is the estimated amount necessary to finance the costs of benefits earned during the year with an additional amount to finance any unfunded accrued liability.

Net Pension Liability: The Primary Health System's net pension liability was measured as of June 30 2016, and the total pension liability used to calculate the net pension liability was determined by an actuarial valuation as of July 1, 2016. The total pension liability in the actuarial valuation was determined using the following actuarial assumptions, applied to all periods included in the measurement:

Inflation	2.5%
Salary increases	N/A
Investment rate of return	7.5%
Discount rate	7.5%

Mortality rates were based on the RP-2014 Mortality for Employees, Healthy Annuitants, and Disabled Annuitants, with generational projection per MP-2015.

The long-term expected rate of return on pension plan investments was determined by applying the most recent capital market assumptions, as developed by the investment manager, using a building block approach. The target allocation and best estimates of arithmetic real rates of return for each major asset class are summarized as follows:

Asset Class	*Target Allocation*	*Long-term Expected Real Rate of Return*
Large cap equity	15.00%	8.00%
Alternative investments	35.00%	7.00%
Mid/Small cap equity	10.00%	8.75%
International equity	20.00%	7.50%
Fixed income	15.00%	6.70%
Real estate	5.00%	5.19%

The pension plan's fiduciary net position was projected to be available to make all projected future benefit payments of current active and inactive employees assuming the actuarially determine contributions are made each year, although not required by the funding policy. Therefore, the discount rate for determining the total pension liability is equal to the long-term expected rate of return on pension plan investments.

Changes in the Net Pension Liability:

Changes in the Primary Health System's net pension liability are as follows for the year ended June 30, 2016:

	Total Pension Liability	*Plan Fiduciary Net Position*	*Net Pension Liability*
Balance, June 30, 2015	$ 128,113,247	$ 76,255,784	$ 51,857,463
Interest	9,054,674	-	9,054,674
Liability gains or losses	3,599,202	-	3,599,202
Assumptions changes	(329,629)	-	(329,629)
Benefit payments	(15,040,450)	(15,040,450)	-
Administrative expenses	-	(592,487)	592,487
Investment income	-	5,213,980	(5,213,980)
Investment gains or losses	-	(9,278,173)	9,278,173
Employer contributions	-	2,000,004	(2,000,004)
Balance, June 30, 2016	$ 125,397,044	$ 58,558,658	$ 66,838,386

The following presents the net pension liability of the Primary Health System calculated using the current discount rate of 7.5 percent, as well as what the net pension liability would be if it were calculated using a discount rate that is 1-percentage-point lower (6.5%) or 1-percentage-point higher (8.5%) than the current rate:

	1% Decrease 6.5%	*Current Rate 7.5%*	*1% Increase 8.5%*
Net pension liability	$ 75,140,950	$ 66,838,386	$ 59,541,706

Pension Expense and Deferred Outflows and Deferred Inflows of Resources: For the year ended June 30, 2016, the Primary Health System recognized pension expense totaling $7,821,331. At June 30, 2016, the Primary Health System reported deferred outflows of resources and deferred inflows of resources from the following sources:

	Deferred Outflows	*Deferred Inflows*
Differences between expected and actual experience	$ 2,852,480	$ 250,151
Changes of assumptions	1,478,851	261,241
Differences between projected and actual earnings	8,980,692	-
	$ 13,312,023	$ 511,392

Amounts reported as deferred outflows of resources and deferred inflows of resources related to pensions will be recognized in pension expense as follows:

Year Ending June 30,	
2017	$ 3,388,150
2018	3,388,150
2019	3,388,150
2020	2,636,181

NOTE I--OTHER RETIREMENT PLANS

The Primary Health System maintains and administers defined contribution plans under Section 403(b) and 401(a) of the IRC which provides for voluntary contributions by employees. The Plans are for the benefit of all employees 25 years of age or older with at least 12 months of employment.

The Primary Health System matches 50% of each participant's contribution up to 2% of the participant's earnings. For eligible employees hired on or after July 1, 2009, the Primary Health System will make profit sharing contributions equal to 3% of their earnings, regardless if the employee is making contributions. Additionally, active employees in the frozen pension plan will receive an additional 2.5% contribution through fiscal year 2019. Employer and employee contributions to the plans were approximately $2,140,000 and $8,250,000, respectively for the year ended June 30, 2016.

NOTE J--MEDICAL MALPRACTICE AND GENERAL LIABILITY CLAIMS

As of January 1, 1976, the Primary Health System adopted a self-insurance plan to provide for malpractice and general liability claims and expenses arising from services rendered subsequent to that date. In 1980, the Primary Health System's Self-Insurance Trust Agreement (the Agreement) was amended to include all coverages that a general public liability insurance policy would cover. In 1988, the Agreement was amended and restated to comply with amendments to the Tennessee Governmental Tort Liability Act and to formally include any claims and expenses related to acts of employees of the Primary Health System. The Primary Health System is funding actuarial estimated liabilities through a revocable trust fund with a bank. The trust assets are included as a part of assets limited as to use in the accompanying combined statements of net position. Such amounts in the trust can be withdrawn by the Primary Health System only to the extent there is an actuarially determined excess. The annual deposit to the self-insurance trust fund is determined by management based on known and threatened claims, consultation with legal counsel, and a report of an independent actuary. Losses against the Primary Health System are generally limited by the Tennessee Governmental Tort Liability Act to $300,000 for injury or death to any one person in any one occurrence or $700,000 in the aggregate. However, claims against healthcare practitioners are not subject to the foregoing limits applicable to the Primary Health System. Any such individuals employed by the Primary Health System, excluding employed physicians for which the Primary Health System has purchased insurance coverage, are covered by the Trust to the limits set forth therein.

In the opinion of management, the revocable trust fund assets are adequate at June 30, 2016 to cover potential liability and malpractice claims and expenses that may have been incurred to that date.

The Primary Health System provides for claims and expenses in the period in which the incidence related to such claims occur based on historical experience and consultation with legal counsel. It is the opinion of management that the reserve for estimated losses and loss adjustment expense at June 30, 2016 is adequate to cover potential liability and malpractice claims which may have been incurred but not reported (IBNR) to the Primary Health System. Such reserve for IBNR claims reflects a discount rate of 5.5% based on the Primary Health System's expected investment return during the payout period.

NOTE K--COMMITMENTS AND CONTINGENCIES

Litigation: The Primary Health System is subject to claims and suits which arise in the ordinary course of business. In the opinion of management, the ultimate resolution of such pending legal proceedings has been adequately provided for in its combined financial statements, and will not have a material effect on the Primary Health System's results of operations or financial position.

Workers Compensation: The Primary Health System has a job injury program to provide benefits to workers injured in employment-related accidents. This program provides medical and indemnity benefits to employees injured in the course of employment for a period up to 24 months from the date of injury. The Primary Health System has recorded a projected liability that is included in other long-term liabilities in the combined statements of net position. The projected liability was discounted using a 4% rate of return at June 30, 2016.

Healthcare Benefits: The Primary Health System maintains a self-insured healthcare plan to provide reimbursement for healthcare expenses for covered employees. The Primary Health System has estimated and recorded a liability for claims incurred but not reported in the combined financial statements.

Service Agreements: The Primary Health System has entered into various long-term service agreements. Early termination of the agreements could result in fees, penalties and reimbursement of various renovation expenses.

Electronic Health Records: The American Recovery and Reinvestment Act of 2009 and the Health Information Technology for Economic and Clinical Health (HITECH) Act established incentive payments under the Medicare and Medicaid programs for healthcare providers that use certified Electronic Health Record (EHR) technology. To qualify for incentive payments, healthcare providers must meet designated EHR meaningful use criteria as defined by the Centers for Medicare & Medicaid Services (CMS). Incentive payments are awarded to healthcare providers who have attested to CMS that applicable meaningful use criteria have been met. Compliance with meaningful use criteria is subject to audit by the federal government or its designee and incentive payments are subject to adjustment in a future period. Beginning October 1, 2015, healthcare providers are subject to a payment adjustment for services provided to Medicare patients if EHR meaningful use criteria are not met each year unless a hardship exemption is requested and approved.

Regulatory Compliance: The healthcare industry is subject to numerous laws and regulations of federal, state and local governments. These laws and regulations include, but are not necessarily limited to, matters such as licensure, accreditation, government healthcare program participation requirements, reimbursement for patient services, Medicare fraud and abuse, and most recently under the Provision of Health Insurance Portability and Accountability Act of 1996, matters

related to patient records, privacy and security. Recently, government activity has increased with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by healthcare providers, such as the Medicare Recovery Audit Contractor Program. Violations of these laws and regulations could result in expulsion from government healthcare programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed. Compliance with such laws and regulations can be subject to future government review and interpretation as well as regulatory actions unknown or unasserted at this time.

In the normal course of business, the Primary Health System continuously monitors and investigates potential issues through its compliance program. Management believes that the Primary Health System is in compliance with applicable laws and regulations or has reported any amounts payable related to known violations, including amounts identified through the Medicare Recovery Audit Contractor program, or similar initiatives, and any settlements will not have a significant impact on the combined financial statements. However, due to the uncertainties involved and the status of ongoing investigations, management's estimate could change in the near future and the amount of the change could be significant.

Health Care Reform: In March 2010, Congress adopted comprehensive healthcare insurance legislation, Patient Care Protection and Affordable Care Act and Health Care and Education Reconciliation Act. The legislation, among other matters, is designated to expand access to coverage to substantively all citizens through a combination of public program expansion and private industry health insurance. Changes to existing TennCare and Medicaid coverage and payments are also expected to occur as a result of this legislation. Implementing regulations are generally required for these legislative acts, which are to be adopted over a period of years and, accordingly, the specific impact of any future regulations is not determinable.

NOTE L--LEASES

Capital: During 2012, the Primary Health System entered into an agreement to sell certain professional office buildings (POBs) and concurrently entered into agreements to lease space from the purchaser. The sales price of the POBs was approximately $13,333,000, and a gain of approximately $6,695,000 was realized. Since the Primary Health System is leasing back certain space, a portion of the gain has been deferred and is being recognized over the terms of the leases. Amortization of the deferred gain is included in non-operating revenue (expenses) for the year ended June 30, 2016. The leases entered into (or committed to) under this sale/leaseback agreement include certain leases which meet the criteria for capitalization. Interest on these leases has been estimated at 7% per annum.

During 2011, the Primary Health System acquired a parcel of land from the Industrial Development Board of the City of Chattanooga, Tennessee for a nominal amount. The Primary Health System also entered into a project development agreement with a developer to facilitate final design, financing and construction of a medical office building for the benefit of Volkswagen Group of America Chattanooga Operations, LLC (Volkswagen) on this land. The Primary Health System has entered into a forty-year ground lease, with the option of two ten-year renewal terms, of the parcel to the developer. Additionally, in 2012, the Primary Health System has entered into a twenty year lease with the developer for certain space in the medical office building for a wellness center and other operations under a capital lease agreement.

The following is a summary of the net book value of property under capital leases by major classes at June 30, 2016:

	Primary Health System
Buildings	$ 6,599,976
Equipment	79,333
	6,679,309
Less: accumulated amortization	(1,931,330)
	$ 4,747,979

The following is a schedule of future minimum lease payments under capital leases:

Year Ending June 30,	
2017	$ 729,999
2018	744,453
2019	759,311
2020	774,587
2021	790,291
2022-2026	3,676,681
2027-2031	3,915,513
2032-2033	525,606
Total minimum lease payments	11,916,441
Less: amount representing interest	(5,699,085)
Present value of minimum lease payments	$ 6,217,356

Operating: The Primary Health System rents office space and office equipment under non-cancelable operating leases through 2033, containing various lease terms. The leases have other

various provisions, including sharing of certain executory costs. Rent expense under operating leases was approximately $13,770,000 in 2016.

Future minimum lease commitments for all non-cancelable leases with terms in excess of one year are as follows:

Year Ending June 30,	
2017	$ 10,098,527
2018	8,043,773
2019	7,722,607
2020	5,980,454
2021	4,022,310
Thereafter	19,354,204
	$ 55,221,875

Rental Revenues: The Primary Health System leases office space to physicians and others under various lease agreements with terms in excess of one year. Rental revenue recognized for the years ended June 30, 2016 totaled approximately $2,962,000. The following is a schedule of future minimum lease payments to be received:

Year Ending June 30,	
2017	$ 2,117,501
2018	402,827
2019	184,753
2020	136,991
2021	85,615
Thereafter	286,010
	$ 3,213,697

NOTE M--FAIR VALUE MEASUREMENTS

The Primary Health System categorizes its fair value measurements within the fair value hierarchy established by generally accepted accounting principles. The hierarchy is based on the valuation inputs used to measure the fair value of the asset. Level 1 inputs are quoted prices in active markets for identical assets or liabilities; Level 2 inputs are significant other observable inputs; Level 3 inputs are significant unobservable inputs.

The Primary Health System has the following recurring fair value measurements as of June 30, 2016:

	Carrying Value	*Level 1*	*Level 2*	*Level 3*
U.S. Treasury obligations	$ 39,303,272	$ 39,303,272	$ -	$ -
U.S. government agency obligations	83,978,073	-	83,978,073	-
Municipal bonds	23,177,684	-	23,177,684	-
Corporate bonds	526,965	-	526,965	-
Bond mutual funds	5,175,552	5,175,552	-	-
Cash and cash equivalents	6,330,553	6,330,553	-	-

The fair value of investments in U.S. government agency bonds, municipal bonds and corporate bonds is estimated based on matrix pricing of similar assets or market corroborated pricing.

NOTE N--MANAGEMENT AGREEMENT

On April 13, 2011, the Primary Health System's Board of Trustees approved a resolution authorizing a management agreement (the Agreement) between the Primary Health System, Hutcheson Medical Center, Inc. and affiliates (collectively, Hutcheson) and the Hospital Authority of Walker, Dade and Catoosa Counties in Georgia (the Hospital Authority).

Under the terms of the Agreement, the Primary Health System proposed general operating policies and directives for Hutcheson; was responsible for the day-to-day management of Hutcheson and provided oversight of ancillary aspects of Hutcheson, such as physician practices, education, research, and clinical services. The Agreement's initial term was to be through March 31, 2021 with the Primary Health System to have the option to extend the agreement for two additional five year terms. The Primary Health System was authorized to terminate the Agreement, without cause, upon written notice at any point subsequent to May 25, 2013. Upon such termination, Hutcheson was to be obligated to make a Termination Payment to the Primary Health System consisting of all expenses then owed by Hutcheson and any outstanding advances under a Line of Credit Agreement, discussed below. Hutcheson could also terminate the agreement without cause at any point subsequent to May 25, 2013 by paying the Termination Payment, as well as the lesser of a) $1,000,000 per year for each year the Agreement has been in place, or b) $1,000,000 less any management fees paid in each Agreement year.

In addition to the Agreement, the Primary Health System agreed to extend a Line of Credit (the Line) to the Hospital Authority. The maximum amount available under the Line was $20,000,000 and at June 30, 2016, the draws on the Line totaled $20,000,000. The Line called for interest only payments each month on the outstanding balance, based on the London InterBank Offered Rate plus 4% or a rate of 5%, whichever is greater. However, any unpaid interest through March 31, 2013 was deferred and to be paid over a twelve-month period

commencing on that date. All outstanding draws were due at the maturity date, which is consistent with the Agreement termination dates, discussed above.

The Line was secured by a Security Agreement on the primary Hutcheson medical campus. Further, the Counties of Walker and Catoosa, Georgia (collectively, the Counties) provided additional security in the form of guarantees under an Intergovernmental Agreement. Under the Intergovernmental Agreement, the Counties each agreed to a maximum liability of $10,000,000 to secure the line. The form of such guarantee was at the option of the Counties and was to become enforceable upon a notice of default delivered by the Primary Health System. The form of the guarantee selected by the Counties can include a) a payment of 50% by each County of the amounts owing under the Line, b) payments as they become due up to the respective $10,000,000 limits or c) after non-Judicial foreclosure under the Security Agreement, each County could elect to pay 50% of any deficiency between the amount outstanding under the Line and the then fair market value. Both Counties previously agreed to levy annual property taxes, if needed to honor these guarantees.

In June 2013, the Agreement was modified to allow Hutcheson to issue requests for proposals for the lease or sale of Hutcheson properties without creating a breach of the Agreement. As part of the Agreement, Hutcheson committed to obtain alternative financing and repay the line of credit upon the earlier of the replacement financing being obtained by Hutcheson, or June 1, 2014. In August of 2013, however, Hutcheson terminated the Agreement. In response thereto, the Primary Health System declared Hutcheson to be in default under the Agreement and made formal demand of Hutcheson as to all amounts then due and payable. In February 2014, the Primary Health System filed suit against Hutcheson in order to collect the moneys, including principal, interest and penalties, then due. In response to such filing, Hutcheson has asserted multiple counter claims against the Primary Health System alleging mismanagement and other failures under the Agreement. Additionally, another senior creditor has filed a separate lawsuit against the Primary Health System alleging priority over the Primary Health System's security interest and, presumably, the County guarantees relating to Hutcheson. The litigation was filed in the United States District Court in the Northern District of Georgia, Rome Division.

During the pendency of the litigation, Hutcheson's operating entities (Hutcheson Medical Center, Inc. and Hutcheson Medical Division, Inc., but not the Hospital Authority) filed for Chapter 11 bankruptcy protection in the Northern District of Georgia. Such filing automatically stayed the pending litigation to the extent it pertained to Hutcheson's operating entities. On September 15, 2015, the Bankruptcy Court did appoint a Chapter 11 Trustee in order to facilitate a sale of Hutcheson's interests and to consider conversion to a Chapter 7 under the Bankruptcy Code. Following the filing of adverse proceedings by the Primary Health System against the Hutcheson entities with the Bankruptcy Court, the parties reached an agreement as to the sale and disposition of the entities' primary assets, including its skilled nursing facility and acute care hospital. As a result of the same, the Primary Health System was paid a total of $2,590,000 from

such sale and, further, the Bankruptcy Court made various findings of fact to enable the Primary Health System to pursue its guarantees against Walker and Catoosa County. Per the Agreement and the Line, the Counties were entitled to and did receive a credit against their guarantees. The Primary Health System remains tangentially involved in the bankruptcy action to ensure that any of its interests remain adequately protected. That portion of the litigation relating to the Hospital Authority, which is unable to seek bankruptcy protection under Georgia law, did continue for a period of time parallel to the bankruptcy proceeding and ultimately resulted in judgment in the Primary Health System's favor in the amount of $36,500,000. The Hospital Authority is apparently judgment-proof and has no material assets at this point. The Primary Health System remains a judgment creditor against the Hospital Authority.

Regions Bank (Regions) is also a creditor of Hutcheson and initiated related litigation in the U.S. District Court for the Northern District of Georgia in Rome (Case No. 4:14-cv-00191) against the Primary Health System in its effort to protect its interest, if any, in the litigation. Specifically, Regions claims the Primary Health System's interest is subordinate to its interest and seeks a declaration of such priority. Regions claims that Hutcheson owes Regions in excess of $22.3 million that is allegedly a senior debt to the debt Hutcheson owes to the Primary Health System. Regions further claims that the Primary Health System's attempted foreclosure constitutes a breach of the Management Agreement to which Regions is allegedly a third party beneficiary and related contracts. Regions filed a Motion for a temporary restraining order on July 28, 2014, seeking to enjoin the foreclosure proceedings. The Court denied Regions Motion for a temporary restraining order as moot in light of the injunctive relief it granted to Hutcheson in the related litigation. Regions filed a second Motion for a temporary restraining order on October 15, 2014, which was heard on October 24, 2014. The Court again denied the Motion for a temporary restraining order as moot due to the injunctive relief granted to Hutcheson in the related litigation. The Primary Health System filed a Motion to Dismiss in the Regions suit, which was granted on October 29, 2014 and dismissed all claims against the Primary Health System in their entirety. Regions appealed the dismissal to the 11th Circuit. As part of the agreement reached in the adverse action filed by the Primary Health System in the Bankruptcy Court (as referenced above), Regions agreed to dismiss its appeal with prejudice.

On or about December 28, 2015, Erlanger filed suit against Walker County in the United States District Court for the Northern District of Georgia in Rome (Case No. 4:15-cv-00250) to enforce its guarantee on the remaining amount of $8,705,000 (in consideration of the credit referenced above). On August 23, 2016, the Court granted the Primary Health System's motion for summary judgment for such amount. Shortly thereafter, Walker County filed a notice of appeal to the Eleventh Circuit Court of Appeals. Walker County's brief is currently due on October 3, 2016.

Rather than file suit directly against Catoosa County, the Primary Health System worked with and negotiated a settlement agreement resolving all claims under the guarantee as to Catoosa County for the lump-sum payment of $6,250,000. Such amounts were paid in full in 2016.

NOTE O--CONDENSED FINANCIAL INFORMATION

The following is condensed, financial information related to the discretely presented component units as of and for the year ended June 30, 2016:

	ContinuCare	*Cyberknife*
Due from other governments	$ 70,516	$ 425,700
Other current assets	12,526,838	787,977
Total Current Assets	12,597,354	1,213,677
Net property, plant and equipment	4,942,125	3,050,319
Other assets	460,454	48,951
Total Assets	$ 17,999,933	$ 4,312,947
Due to other governments	$ 254,856	$ -
Other current liabilities	2,787,377	2,655,567
Total Current Liabilities	3,042,233	2,655,567
Long-term debt and capital lease obligations	314,397	-
Total Liabilities	3,356,630	2,655,567
Net position		
Unrestricted	9,725,951	1,050,691
Net investment in capital assets	4,917,352	606,689
Total Net Position	14,643,303	1,657,380
Total Liabilities and Net Position	$ 17,999,933	$ 4,312,947
Year Ended June 30, 2016		
Net patient and operating revenue	$ 31,067,632	$ 2,204,467
Operating expenses:		
Salaries, wages and benefits	13,865,466	252,113
Supplies and other expenses	15,284,704	682,729
Depreciation	582,102	658,225
Total Operating Expenses	29,732,272	1,593,067
Operating Income	1,335,360	611,400

	ContinuCare	*Cyberknife*
Nonoperating expenses	(469,918)	(123,593)
Operating distributions	-	(178,000)
Change in Net Position	865,442	309,807
Net Position at Beginning of Period	13,777,861	1,347,573
Net Position at End of Period	$ 14,643,303	$ 1,657,380

ContinuCare owes the Primary Health System for various services, supplies, and rents provided, or expenses paid on its behalf. Actual expenses incurred related to these services were approximately $2,386,000 in 2016. In addition, ContinuCare provides staffing, contract nurse visits, and administrative services to the Primary Health System. Revenues from such services were approximately $530,000 for the year ended June 30, 2016. Amounts due at June 30, 2016 are included in amounts due to/from other governments in the accompanying combined financial statements.

The Primary Health System owes Cyberknife for radiation services provided by Cyberknife to the Primary Health System's patients. Revenues related to those services provided to the Primary Health System were approximately $2,200,000 in 2016. Amounts due at June 30, 2016 are included in amounts due to/from other governments in the accompanying combined financial statements.

Required Supplementary Information

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
(d/b/a Erlanger Health System)

Schedule of Changes in Net Pension Liability and Related Ratios

Year Ended June 30, 2016

	2015	*2016*
Total pension liability		
Interest	$ 9,278,335	$ 9,054,674
Differences between expected and actual experience	(386,473)	3,599,202
Changes of assumptions or inputs	2,284,765	(329,629)
Benefit payments	(13,308,452)	(15,040,450)
Net change in total pension liability	(2,131,825)	(2,716,203)
Total pension liability, beginning of year	130,245,072	128,113,247
Total pension liability, end of year	$128,113,247	$125,397,044
Plan fiduciary net position		
Contributions - employer	$ 1,000,000	$ 2,000,004
Net investment income, net	3,325,595	(4,064,193)
Benefit payments	(13,308,452)	(15,040,450)
Administrative expense	(515,072)	(592,487)
Net change in plan fiduciary net position	(9,497,929)	(17,697,126)
Plan fiduciary net position, beginningof year	85,753,713	76,255,784
Plan fiduciary net position, end of year	$ 76,255,784	$ 58,558,658
Net pension liability, end of year	$ 51,857,463	$ 66,838,386
Fiduciary net position as a percentage of the total pension liability	59.52%	46.70%
Covered-employee payroll	$115,717,311	$117,027,000
Net pension liability as a percentage of covered-employee payroll	44.81%	57.11%

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY
(d/b/a Erlanger Health System)

Schedule of Actuarial Contributions

Year Ended June 30, 2016

	2016	2015	2014	2013	2012	2011	2010	2009	2008	2007
Actuarially determined contributions	$ 4,957,642	$ 4,364,255	$ 12,832,292	$ 11,165,101	$ 10,367,973	$ 8,833,977	$ 7,501,004	$ 7,192,948	$ 6,731,386	$ 8,261,320
Actual employer contributions	2,000,004	1,000,000	-	11,165,101	10,367,970	8,833,977	7,501,004	7,192,000	6,172,593	7,590,497
Contribution deficiency	$ 2,957,638	$ 3,364,255	$ 12,832,292	$ -	$ 3	$ -	$ -	$ 948	$ 558,793	$ 670,823
Covered-employee payroll	$117,026,565	$115,717,311	$121,093,695	$138,807,819	$147,947,134	$144,176,724	$139,291,860	$138,478,848	$127,662,977	$134,278,637
Contributions as a percentage of covered-employee payroll	1.71%	0.86%	0.00%	8.04%	7.01%	6.13%	5.39%	5.19%	4.84%	5.65%

Notes to Schedule:

Valuation date:	Actuarially determined contribution rates are calculated as of June 30, one year prior to the end of the fiscal year in which contributions are reported.
Actuarial cost method:	Entry age normal
Amortization method:	Level dollar, closed
Amortization period:	18 years
Asset valuation method:	4-year smoothed market
Inflation:	2.5%
Lump sum interest rate:	4.0%
Salary increases:	N/A
Investment rate of return:	7.25%
Retirement age:	Normal retirement at 65 years, early retirement at 55 years with 10 years of service
Mortality:	RP-2014 Mortality for Employees, Health Annuitants, and Disabled Annuitants with general projection per MP-2015 in 2016 RP-2014 Mortality for Employees, Health Annuitants, and Disabled Annuitants with general projection per MP-2014 in 2015 RP-2000 Mortality for Employees, Health Annuitants, and Disabled Annuitants projected to 2018 per Scale AA in 2014

Description	Section / Item
List Of Erlanger Patient Transfer Agreements	B-III-1

Description	Section / Item
Statement Of Deficiencies & Plan Of Correction	B-III-4

PRINTED: 05/22/2017
FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TNP5315	A. BUILDING: _____ B. WING _____	05/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ERLANGER BLEDSOE HOSPITAL	71 WHEELERTOWN AVENUE PIKEVILLE, TN 37367

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
P 001	1200-8-30 Initial During a licensure survey completed on 5/17/17 at Erlanger Bledsoe Hospital, no deficiencies were cited under Chapter 1200-8-30, Standards for Pediatric Emergency Care Facilities.	P 001		

Division of Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

TN Department of Health

May 24, 2017

Ms. Stephanie Boynton, Administrator
Erlanger Bledsoe Hospital
71 Wheelertown Avenue
Pikeville TN 37367

RE: TNP5315

Dear Ms. Boynton:

The East Tennessee Regional Office conducted a licensure survey at your facility on May 17, 2017. As a result of the survey, no deficiencies were cited under Standards of Pediatric Emergency Care (1200-8-30).

If our office may be of assistance to you, please feel free to call (865) 594-9396.

Sincerely,

Tamra Turberville/cw

Tamra Turberville, RN, MSN
Public Health Regional Regulatory Program Manger

TT: cw

Department of Health & Human Services
Centers for Medicare & Medicaid Services
61 Forsyth Street, SW, Suite 4T20
Atlanta, Georgia 30303-8909

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

June 15, 2017

Stephanie Boynton, CEO
Erlanger Bledsoe Hospital
71 Wheelertown Avenue
Pikeville, TN 37367

Dear Mrs. Boynton:

I am pleased to inform you that as a result of the validation survey conducted on May 17, 2017, by the Tennessee State Agency, your facility was found in compliance with the Medicare requirements to participate as a Hospital and will continue to be deemed to meet applicable Medicare requirements based upon accreditation by the Joint Commission.

Enclosed is a listing of the standard level deficiencies and life safety deficiencies found by the Tennessee State Agency. Since your hospital is in compliance, you do not have to submit a plan for correcting any of the Medicare deficiencies cited. However, you may wish to submit a plan of correction to include with any public disclosures. The plan of correction can be submitted to the address above or faxed to 443-380-5912. You may also email to jacqueline.whitlock@cms.hhs.gov. If you have any questions, please contact Jackie Whitlock at (404) 562- 7437.

Sincerely,

J. Whitlock
for Sandra M. Pace
Associate Consortium Administrator
Division of Survey & Certification

cc: Joint Commission
Tennessee State Agency

Supplemental #1
(COPY)

Chattanooga-Hamilton Co Hospital Authority dba Erlanger Sequatchie Valley Regional Hospital (Pikeville)

CN1709-028

SUPPLEMENTAL #1
September 22, 2017
10:08 am

SUPPLEMENTAL INFORMATION

Chattanooga-Hamilton County Hospital Authority

D / B / A

Erlanger Sequatchie Valley Regional Hospital

Application To Relocate & Replace The Existing

Provider Based (Free Standing) Emergency Department From

Erlanger Bledsoe Hospital – Satellite ED
(Dunlap, Sequatchie County, TN)

To

Erlanger Sequatchie Valley Regional Hospital – Satellite ED
(Pikeville, Bledsoe County, TN)

Application Number CN1709-028

ERLANGER HEALTH SYSTEM
Chattanooga, Tennessee

SUPPLEMENTAL #1
September 22, 2017
10:08 am

Supplemental Responses To Questions Of The Tennessee Health Services & Development Agency

1.) Section A, Executive Summary.

Please address the following:

- **Please explain why the applicant has chosen not to relocate the satellite ED at another location within Sequatchie County.**
- **If the proposed project is approved, please explain how the site of the existing satellite ED will be utilized.**

Response

With the relocation of *Erlanger Bledsoe Hospital* to Dunlap, Sequatchie County, Tennessee, an emergency department will be located within *Erlanger Sequatchie Valley Regional Hospital*. We seek to enhance access to care, as such, it is not practical to have the emergency department serve the same rural population.

2.) Section A, Project Details, Item B.

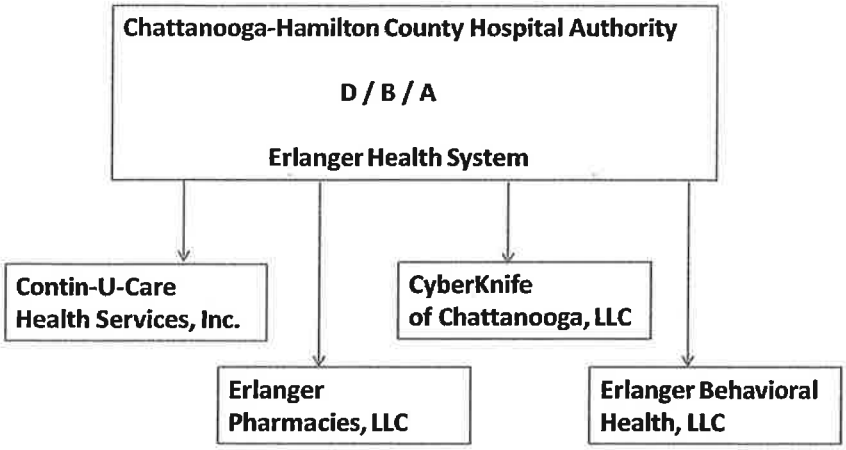
Please describe the existing ownership structure of the applicant, including an ownership structure organizational chart.

Response

The *Chattanooga-Hamilton County Hospital Authority* D/B/A *Erlanger Health System*, is a sub-division of the State of Tennessee. It is a governmental unit. The hospitals which comprise Erlanger Health System are all part of the hospital authority, they operate as revenue center components of the hospital authority.

The organizational structure is comprised of one (1) legal entity, the hospital authority, which has an ownership interest in the following legal entities. These other legal entities are Contin-U-Care Health Services, Inc. (home health), Erlanger Pharmacies, LLC, CyberKnife Of Chattanooga, LLC, and Erlanger Behavioral Health, LLC.

The ownership structure organizational chart is below.



3.) Section A, Project Details, Item 6.A (Legal Interest In The Site).

The option to lease agreement between Bledsoe County and Erlanger Health System is noted. Please provide a deed that confirms Bledsoe County has control of the proposed site.

Response

As requested, a copy of the deed for the property is attached to this supplemental information.

4.) Section A, Project Details, Item 6.B-2 (Floor Plan).

Please provide a floor plan of the proposed satellite ED which includes legible labeling of patient care rooms (noting private or semi-private), ancillary areas, equipment areas, etc.

Please complete the following chart:

Patient Care Areas other than Ancillary Services	# Current Hospital ED	# Current Satellite ED	# Current Combined EDs	# Proposed Hospital ED	# Proposed Satellite ED	# Proposed Combined EDs
Exam/Treatment Rooms						
Multipurpose						
Gynecological						
Holding/Secure/Psychiatric						
Isolation						

Orthopedic						
Trauma						
Other						
Triage Stations						
Decontamination Rooms/Stations						
Total						
Useable SF of Main and Satellite ED's						

In April 2016, a revised publication of the *Emergency Department Design: A Practical Guide to Planning* was released. Please complete the following chart using pages 116 and 117 of the publication.

Emergency Department Design: A Practical Guide to Planning, 2016, American College of Emergency Physicians-High and Low Estimates for dept. areas and beds							
Projected Annual Visit	***Dept. Gross Area***		***Bed Quantities***				
	Low Range	*High Range*	*Low Range Bed Qty.*	*Low Range Visits/Bed*	*High Range Bed Qty.*	*High Range Visits/Bed*	*Estimated Area /Bed*
Applicant- Satellite ED							
Projected Visits Yr. 1	*Total Gross Square Footage*		*Beds*		*Visits Per Bed*		*Estimated Area /Bed*

Response

As requested, floor plan is attached to this supplemental information.

As requested, the charts appear below.

	======== Current ED's =========			======= Proposed ED's ========		
	Hospital	Satellite	Total	Hospital	Satellite	Total
Exam / Treatment Rooms	1	3	4	4	2	6
Multi-Purpose			0	3	2	5
Gynecological			0			0
Holding / Secure / Psychiatric			0			0
Isolation			0			0
Orthopedic			0	1	1	2
Trauma	1		1		1	1
Other	3	2	5	2	4	6
Triage Stations			0		1	1
Decontamination Rooms / Stations			0		1	1
Total	5	5	10	10	12	22
Useable SF Of Main & Satellite ED's	3,830	5,100	8,930	11,200	8,100	19,300

Emergency Department Design: A Practical Guide To Planning - 2016, American College Of Emergency Physicians High And Low Estimates For Dept. Areas And Beds							
Projected Annual Visits	=== Dept. Gross Area ===		========== Bed Quantities ==========				
			===== Low Range =====		===== High Range =====		Est. Area
	Low Range	High Range	Bed Qty.	Visits / Bed	Bed Qty.	Visits / Bed	Per Bed
11,200	4,323	6,877	4	541	6	573	1,200

Applicant Satellite ED				Est. Area
Projected Visits - Year 1	Total Gross Square Footage	Beds	Visits Per Bed	Per Bed
5,600	8,100	12	466	675

5.) Section A, Project Details, Item 10(c) (Bed Complement Data).

The applicant lists two outstanding Certificate of Need projects. However, the outstanding Certificate of Need projects listed are those of Erlanger Medical Center that has common ownership. Please submit a replacement page 17 listing only those Certificate of Need projects for the applicant.

Response

As requested, the CON's not related to *Erlanger Bledsoe Hospital* have been removed from the list, and a replacement page 17 is attached to this CON application.

6.) Section B, Need, Item 1 (Project Specific Criteria - Freestanding Emergency Department), Determination Of Need.

Please discuss where the satellite ED falls with respect to being low range, mid range, or high range acuity. See pages 109-112 of the ACEP Emergency Department Design: A Practical Guide To Planning, in making this determination.

Please compare the metrics on page 31 of the application to statewide and national averages.

Response

Being located in a rural area, most of the visits to *Erlanger Sequatchie Valley Regional Hospital – Satellite ED*

are expected to be primarily low range visits. However, on a periodic basis there may be high range visits or trauma related visits.

As requested, the metrics for Erlanger Bledsoe Hospital are compared to the state and national averages.

Ind.	*Description*	*Erlanger Bledsoe*	*State & National*
OP-4	Aspirin At Arrival	99 %	96 %
OP-18	Median Time From ED Arrival To Departure For Discharged ED Patients	95 min.	138 min.
OP-20	Door To Diagnostic Eval	25 min.	21 min.
OP-21	Median Time To Pain Med	49 min.	50 min.
OP-22	Left Before Being Seen	2 %	2 %

7.) Section B, Need, Item A (Specific Service Criteria-Freestanding Emergency Department), Establishment of Non-Rural Service Area.

For the most recent please provide patient origin by county for both the satellite ED in Sequatchie County and the hospital ED in Bledsoe County.

Response

As requested, the patient origin for each ED is below.

Erlanger Bledsoe Hospital - ED
Patient Origin - 2016

	ED Visits	%
BLEDSOE, TN	4,592	82.8%
SEQUATCHIE, TN	344	6.2%
RHEA, TN	189	3.4%
HAMILTON, TN	128	2.3%
VAN BUREN, TN	116	2.1%
CUMBERLAND, TN	78	1.4%
Other	99	1.8%
Total	5,546	100.0%

Erlanger Bledsoe Hospital - Satellite ED
Patient Origin - 2016

	ED Visits	%
SEQUATCHIE, TN	6,420	62.8%
MARION, TN	1,548	15.1%
BLEDSOE, TN	661	6.5%
GRUNDY, TN	529	5.2%
HAMILTON, TN	529	5.2%
RHEA, TN	93	0.9%
VAN BUREN, TN	39	0.4%
Other	410	3.9%
Total	10,229	100.0%

8.) Section B, Need, Item A (Specific Service Criteria-Freestanding Emergency Department), Pediatric Care.

Please address the following.

- **Applicants should demonstrate a commitment to maintaining at least a Primary Level of pediatric care at the FSED as defined by CHAPTER 1200-08-30, Standards For Pediatric Emergency Care Facilities, including staffing levels, pediatric equipment, staff training, and pediatric services.**
- **Applicants should include information detailing the expertise, capabilities, and/or training of staff to stabilize or serve pediatric patients.**

Response

Erlanger Sequatchie Valley Regional Hospital provider based ED will have an affiliation agreement with Erlanger Children's Hospital, the designated regional pediatric center.

9.) Section B, Need, Item 1 (Specific Service Criteria-Freestanding Emergency Department), Stabilization And Transfer For Emergent Cases.

Please indicate average air travel time (helicopter) from the proposed satellite ED to Erlanger Medical Center (Hamilton County) in an emergent situation.

Response

The average air travel time from Pikeville, Tennessee, to Erlanger Medical Center in Hamilton County, Tennessee, is seventeen (17) minutes.

10.) Section B, Need, Item 1 (Specific Service Criteria-Freestanding Emergency Department), Community Linkage Plan.

What is the community linkage plan for behavioral and substance abuse providers assuring continuity of care.

Response

The community linkage plan related to behavioral health and substance abuse is to have a patient transfer agreement in place when the *Erlanger Behavioral Health* hospital is licensed for occupancy, it is currently under construction (CON No. CN1603-012). Further, please see the attached letter from Jennie Mahaffey, M.D., which states that *Erlanger Behavioral Health* services will be available to Erlanger Sequatchie Valley Regional Hospital in both locations, to include the hospital and the satellite ED.

11.) Section B, Need, Item D.1 (Service Area Demogrpahics).

Please complete the following chart.

Demographic Data	Bledsoe County	State of TN Total
65 + Pop. - 2017		
65+ Pop. - 2021		
65+ Population % Change (2017-2021)		
65+ Population % of Total Population		

Response

As requested, the chart has been completed.

Demographic Data - Age 65 +

	Bledsoe	Tennessee Total
Pop. Age 65 + (2017)	2,450	1,078,446
Pop. Age 65 + (2021)	2,720	1,227,838
65 + Pop. % Change (2017-2021)	11.0%	13.9%
66 + Pop. % Of Total Population	20.8%	17.9%

12.) Section B, Need, Item E.

The table on page 57 indicating the ED patient destination from Bledsoe County is noted. However, please include a column indicating the percentage change from 2014 to 2016 and submit a replacement page.

Please identify existing urgent care centers in Bledsoe County by completing the following table.

Urgent Care Centers in Bledsoe County

Urgent Care Center Name	Address	Distance from Proposed ED	Operating Hours	Medicare, TennCare, & Major Ins accepted?

Response

As requested, the table has been revised and a replacement is attached to this supplemental information.

As requested, the table showing urgent care centers in Bledsoe County appears below.

Urgent Care Centers In Bledsoe County

Urgent Care Canter Name	Address	Distance From Proposed ED	Oper. Hours	Medicare, TennCare & Major Ins. Accepted
Pikeville Urgent Care, PLLC	344 Church Street Pikeville, TN 37363	0.7 mi.	7a-7p	Yes (*)

(*) We do not have any information on charity care & self-pay.

13.) Section B, Need, Item F.

Please complete the following tables.

Erlanger Sequatchie Valley and Satellite ED Historical and Projected Utilization

	Actual			Projected		
Year	2014	2015	2016	Yr 1	Yr.2	Yr. 5
Main Campus Visits						
Main Campus Rooms						
Main Campus Visits/ Room						
Satellite Visits						
Satellite Rooms						
Satellite Visits Per Room						
Total Visits						
Total Rooms						
Total Visits Per Room						

Erlanger Sequatchie Valley and Satellite ED Historical and Projected Utilization
Emergency Severity Index Level of Care

Level of Care	Main ED	Main ED	Main ED	Main ED	Satellite ED	Combined Year 1
	2014	2015	2016	Year 1	Year 1	
Level I						
Level II						
Level III						
Level IV						
Level V						
Total						

Please clarify the reason ED visits at the Dunlap ED increased from 3,842 in 2014 to 10,229 in 2016.

It is noted the Dunlap ED experienced 3,842 ED visits

in 2014. However, the Historical Data Chart on page 65 indicates there were 3,482 ED visits in 2014. Please clarify.

Please provide details of the methodology data sources, assumptions, and rationale to project utilization in Year One and Year Two of the proposed project.

Does the applicant essentially project that the current volumes of the hospital ED and satellite ED will "swap" when both proposed projects relocate to each other's current county ?

Response

The total number of ED visits increased significantly between 2014 and 2016, due primarily to the fact that it opened on July 29, 2014. As such, it was only open for five (5) months of 2014.

The number of ED visits for 2014 was 3,842. The number of visits on the *Historical Data Chart* was a typographical error. A replacement page for the *Historical Data Charts* is attached to this supplemental information.

Yes, applicant essentially projects that the current volumes of the hospital ED and satellite ED will "swap" when both of the proposed projects relocate to each other's current county.

As requested, the tables have been completed below.

Erlanger Squatchie Valley & Satellite ED -- Historical & Projected Utilization

	Actual			Projected		
	2014	2015	2016	Year 1	Year 2	Year 5
Main Campus Visits	6,105	5,341	5,546	11,000	11,220	11,907
Main Campus Rooms	5	5	5	9	9	9
Main Campus Visits / Room	1,221.0	1,068.2	1,109.2	1,222.2	1,246.7	1,323.0
Satellite Visits	3,842	9,581	10,229	5,600	5,678	5,918
Satellite Rooms	5	5	5	7	7	7
Satellite Visits Per Room	768.4	1,916.2	2,045.8	800.0	811.1	845.4
Total Visits	9,947	14,922	15,775	16,600	16,898	17,825
Total Rooms	10	10	10	16	16	16
Total Visits Per Room	994.7	1,492.2	1,577.5	1,037.5	1,056.1	1,114.1

Erlanger Sequatchie Valley & Satellite ED - Historical & Projected Utilization
Emergency Severity Index - Level Of Care

	========== Main ED ==========			Main ED	Sat. ED	Total
Level Of Care	2014	2015	2016	Year 1	Year 1	Year 1
Level I	17	7	24	23	11	34
Level II	2,215	1,904	2,120	2,140	5,665	7,805
Level III	2,770	2,332	2,351	2,374	4,114	6,488
Level IV	1,024	1,034	967	975	1,108	2,083
Level V	79	64	84	88	102	190
Total	6,105	5,341	5,546	5,600	11,000	16,600

14.) Section B, Economic Feasibility, Item A (Project Cost Chart).

The Project Cost Chart should reflect the cost of the project to the applicant. It appears that much of the cost in this chart is the cost to Bledsoe County. Since the applicant is leasing the hospital from Bledsoe County, the lease expense is what should be considered in determining facility cost. Below is the Agency rule on project cost for guidance:

0720—9—.01 DEFINITIONS. The following terms shall have the following meanings.

(4) "Capital expenditure"

(c) Lease, loan, or gift. In calculating the value of a lease, loan, or gift, the "cost" is the fair market value of the above-described expenditures. In the case of a lease, the cost is the fair market value of the lease or the total amount of the lease payment, whichever is greater.

If necessary, please make the appropriate changes and submit a revised Project Costs Chart.

Response

The hospital lease will be a "turn key" arrangement. In other words, all of the equipment (including CT, etc.), furniture and fixtures will be included in the lease payment to Bledsoe County. The initial lease term will be for ten (10) years. The monthly lease payment to Bledsoe County will $19,482, for a total of $2.38 million over the initial lease term. This is less than the total project cost of $4.4 million shown on the *Project Cost Chart*. As per the rule cited in the question, the chart should

reflect the greater amount. Therefore, the *Project Cost Chart* is unchanged.

15.) Section B, Economic Feasibility, Item A(5) (Architect's Letter).

The July 24, 2017, letter from Gresham Smith and partners is noted. However, it appears the letter supports a combination application. Please submit an architect's letter meeting all the required elements in the application for the proposed project.

Response

As requested, a letter from the architect for this project is attached to this supplemental information.

16.) Section B, Economic Feasibility, Item B (Funding).

The letter from Bledsoe County Mayor is noted. The letter indicates the funding for the proposed satellite ED is subject to underwriting information. It is unclear if Bledsoe County is providing the financing or will be holding a bond. If Bledsoe County will be holding the bond, a letter from the issuing authority stating favorable initial contact and a conditional agreement from an underwriter or investment banker to proceed with the issuance will be needed. If Bledsoe County will be providing financing without a bond issuance, appropriate documentation from a financial institution will be needed to document Bledsoe County has the funds to finance the proposed project.

Please revise page 61 and submit a replacement page that identifies the funding source and refers to the correct supporting documentation in the attachments.

The applicant should also discuss how it will fund the project and provide a breakdown between leased items and purchased items.

Response

As requested, a letter from the underwriter, Cumberland Securities, is attached to this supplemental information.

17.) Section B, Economic Feasibility, Item C (Historical Data Chart).

The Historical Data Chart for the project is noted. However, it appears the Free Cash Flow amount of ($22,070) for 2016 is incorrect. Please confirm and submit a revised Historical Data Chart if needed.

Response

As requested, the error on page 66 - Historical Data Chart - has been corrected. A revised page is attached to this supplemental information.

18.) Section B, Economic Feasibility, Item D.

The Projected Data Chart for the proposed project is noted. However, it is noted the applicant will be providing outpatient services totaling $6,627,925 in Year 1 and $7,078,226 in Year 2 that was not previously provided at the current satellite ED site. Please indicate what type of outpatient services will be provided.

It is noted the applicant projects $168,994 in Year 1 and $174,063 in Year 2 in "other revenue" for non-patient services. Please indicate what those services are.

Response

Outpatient services will be provided at the new location, primarily consisting of rehabilitation services of Physical Therapy, Occupational Therapy and Speech Therapy.

The "Other Revenue" shown on the *Projected Data Chart* will be primarily *Occupational Medicine* for employers in the area. For example, an article was submitted with the CON application highlighting that a new textile plant has announced that they will open on Bledsoe County, with

approximately 1,000 new jobs. *Erlanger Sequatchie Valley Regional Hospital* looks forward to providing needed occupational health services for this and other employers.

19.) Section B, Economic Feasibility, Item E (Average Gross Charge, Average Deduction From Operating Revenue, and Average Net Charge).

The table on page 72 appears to be incorrect. Please complete the table for the gross charge, deduction from revenue, and average net charge from the project's Historical and projected Data Chart and submit a replacement page 72.

Response

As requested, the table has been corrected, and a replacement page is attached to this supplemental information.

20.) Section B, Economic Feasibility, Item H.

The staffing table is noted. However, please indicate how the proposed ED will be staffed. If by contracted emergency physicians, please provide an overview of the contracted organization and their experience.

Please complete the following chart showing the FTE staffing plan for the proposed satellite ED:

Applicant's Projected Staffing of Proposed Satellite ED by Shift

Position	7-3 # FTEs	3-11 # FTEs	11-7 # FTEs
Emergency Medicine Physician			
Director			
Manager			
RN			
Respiratory Therapist			
Lab Tech			
Ultrasound Tech			
MM Tech			
Other			
Total			

Response

The staffing for the provider based ED will be on two (2) shifts per day, 7am-7pm and 7pm-7am.

As requested, the chart has been completed.

Applicant's Projected Staffing Of Proposed Satellite ED By Shift

Position	7a-7p	7p-7a
Emergency Medicine Physician	1	1
Director	1	
Manager	1	1
RN	3	4
Respiratory Therapist	1	1
Lab. Tech.	1	1
Ultrasound Tech.	1	1
Med. Tech.	2	2
Other	8	12
Total	19	23

21.) Section B, Orderly Development, Item 4.

It is noted the hospital license provided is out of date. Please provide a copy of the current license.

It is noted the applicant is Joint Commission accredited. Please provide documentation of the current accreditation and a copy of the latest survey.

Response

The license for *Erlanger Bledsoe Hospital* for 2017-2018 is attached to this supplemental information.

A copy of the letter from *The Joint Commission* documenting current accreditation for *Erlanger Bledsoe Hospital*, is attached to this supplemental information. Also, a copy of the survey report is attached to this supplemental information.

22.) Section B, Quality Measures.

Please discuss the applicant's commitment to the

proposal in meeting appropriate quality standards by addressing each of the following factors:

(a) Whether the applicant commits to maintaining an actual payor mix that is comparable to the payor mix projected in its CON application, particularly as it relates to Medicare, TennCare/Medicaid, Charity Care, and the Medically Indigent;

(b) Whether the applicant commits to maintaining staffing comparable to the staffing chart presented in its CON application;

(c) Whether the applicant will obtain and maintain all applicable state licenses in good standing;

(d) Whether the applicant will obtain and maintain TennCare and Medicare certification(s), if participation in such programs was indicated in the application;

(e) Whether an existing healthcare institution applying for a CON has maintained substantial compliance with applicable federal and state regulation for the three years prior to the CON application. In the event of non-compliance, the nature of non-compliance and corrective action shall be considered;

(f) Whether an existing health care institution applying for a CON has been decertified within the prior three years. This provision shall not apply if a new, unrelated owner applies for a CON related to a previously decertified facility;

(g) Whether the applicant will participate, within 2 years of implementation of the project, in self-assessment and external peer assessment processes used by health care organizations to accurately assess their level of performance in relation to established standards and to implement ways to continuously improve.

a. This may include accreditation by any organization approved by Center for Medicare and Medicaid Services (CMS) and other

nationally recognized programs. The Joint Commission or its successor would be acceptable if applicable. Other acceptable organizations may include, but are not limited to, the following:

American College of Radiology for Positron Emission Tomography, Magnetic Resonance Imaging and Outpatient Diagnostic Center projects;

Response

(a) The applicant commits to maintaining a payor mix consistent with that detailed in the application, as it relates to Medicare, TennCare/Medicaid, Charity Care, and the Medically Indigent.
(b) The applicant commits to maintaining staffing comparable to the staffing chart presented in the CON application.
(c) The applicant will obtain and maintain all applicable state licenses in good standing.
(d) The applicant will obtain and maintain TennCare and Medicare certifications.
(e) The applicant has maintained substantial compliance with applicable federal and state regulation for the three years prior to the CON application.
(f) The applicant has not been decertified within the prior three years.
(g) The applicant will participate, within 2 years of implementation of the project, in self-assessment and external peer assessment processes used by health care organizations to accurately assess its level of performance in relation to established standards and to implement ways to continuously improve.

23.) Proof Of Publication.

Please submit a copy of the full page of the newspaper in which the notice of affidavit which is supplied by the newspaper as proof of the publication of the letter of intent.

Response

The *Affidavit Of Publication* is attached to this supplemental information.

SUPPLEMENTAL #1
September 22, 2017
10:08 am

A F F I D A V I T

STATE OF TENNESSEE |
|
COUNTY OF HAMILTON |

NAME OF FACILITY Erlanger Sequatchie Valley Regional Hospital
Satellite Emergency Department

I, Joseph M. Winick, after first being duly sworn, State under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

SIGNATURE

SWORN to and subscribed before me this 21 of September (Month), 2017 (Year), a Notary Public in and for the State of Tennessee, County of Hamilton.

SHELIA HALL
STATE OF TENNESSEE NOTARY PUBLIC
HAMILTON COUNTY

Sheila Hall
NOTARY PUBLIC

My commission expires June 9 (Month / Day), 2018.

SUPPLEMENTAL #1
September 22, 2017
10:08 am

ATTACHMENTS

SUPPLEMENTAL #1
September 22, 2017
10:08 am

Description	Section / Item
Warranty Deed	
Floor Plan	
Architect Letter	
Financing Letter	
Replacement Pages	
Hospital License	
Joint Commission - Letter Of Accreditation	
Joint Commission - Survey Report	
Affidavit Of Publication	
Letters Of Support	

The Joint Commission

June 22, 2017

Re: # 7809
CCN: #441306
Program: Critical Access Hospital
Accreditation Expiration Date: March 30, 2020

Kevin M. Spiegel
President and CEO
Chattanooga Hamilton County Hospital Authority
975 East Third Street
Chattanooga, Tennessee 37403

Dear Mr. Spiegel:

This letter confirms that your March 27, 2017 - March 29, 2017 unannounced full resurvey was conducted for the purposes of assessing compliance with the Medicare conditions for critical access hospitals, including your swing bed service, through The Joint Commission's deemed status survey process.

Based upon the submission of your evidence of standards compliance on June 15, 2017, the Joint Commission is granting your organization an accreditation decision of Accredited with an effective date of March 30, 2017.

The Joint Commission is also recommending your organization for continued Medicare certification effective March 30, 2017. Please note that the Centers for Medicare and Medicaid Services (CMS) Regional Office (RO) makes the final determination regarding your Medicare participation and the effective date of participation in accordance with the regulations at 42 CFR 489.13. Your organization is encouraged to share a copy of this Medicare recommendation letter with your State Survey Agency.

This recommendation applies to the following locations:

Chattanooga Hamilton County Hospital Authority
d/b/a Erlanger Bledsoe Internal & Pediatric Medicine
136 Wheelertown Avenue, Pikeville, TN, 37367

Chattanooga Hamilton County Hospital Authority
d/b/a Erlanger Sequatchie Valley Emergency Department
16931 Rankin Avenue, Dunlap, TN, 37327-7029

Chattanooga Hamilton County Hospital Authority
d/b/a UT Erlanger Cardiology at Erlanger Bledsoe
121 Wheelertown, Pikeville, TN, 37367

Headquarters
One Renaissance Boulevard
Oakbrook Terrace, IL 60181
630 792 5000 Voice

SUPPLEMENTAL #1
September 22, 2017
10:08 am

The Joint Commission

Erlanger Bledsoe Hospital
71 Wheelertown Avenue, Pikeville, TN, 37367

Please be assured that The Joint Commission will keep the report confidential, except as required by law or court order. To ensure that The Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

Sincerely,

Mark Pelletier

Mark G. Pelletier, RN, MS
Chief Operating Officer
Division of Accreditation and Certification Operations

cc: CMS/Central Office/Survey & Certification Group/Division of Acute Care Services
CMS/Regional Office 4 /Survey and Certification Staff

Headquarters
One Renaissance Boulevard
Oakbrook Terrace, IL 60181
630 792 5000 Voice

The Joint Commission

Official Accreditation Report

Chattanooga Hamilton County Hospital Authority
975 East Third Street
Chattanooga, TN 37403

Organization Identification Number: 7809

Evidence of Standards Compliance (60 Day) Submitted: 6/15/2017

SUPPLEMENTAL #1
September 22, 2017
10:08 am

Executive Summary

Program(s)	Submit Date
Hospital Accreditation Critical Access Hospital Accreditation	6/15/2017

Hospital Accreditation :	As a result of the accreditation activity conducted on the above date(s), there were no Requirements for Improvement identified.
Critical Access Hospital Accreditation :	As a result of the accreditation activity conducted on the above date(s), there were no Requirements for Improvement identified.

If you have any questions, please do not hesitate to contact your Account Executive.

Thank you for collaborating with The Joint Commission to improve the safety and quality of care provided to patients.

SUPPLEMENTAL #1
September 22, 2017
10:08 am

Requirements for Improvement – Summary

As a result of the accreditation activity conducted, there were no Requirements for Improvement identified.

Program	Standard	Level of Compliance
HAP	EC.02.02.01	Compliant
HAP	EC.02.03.03	Compliant
HAP	EC.02.03.05	Compliant
HAP	EC.02.04.03	Compliant
HAP	EC.02.05.01	Compliant
HAP	EC.02.05.05	Compliant
HAP	EC.02.05.07	Compliant
HAP	EC.02.05.09	Compliant
HAP	EC.02.06.01	Compliant
HAP	EC.02.06.05	Compliant
HAP	IC.02.01.01	Compliant
HAP	IC.02.02.01	Compliant
HAP	IM.02.01.03	Compliant
HAP	LD.01.03.01	Compliant
HAP	LD.04.01.05	Compliant
HAP	LS.01.01.01	Compliant
HAP	LS.01.02.01	Compliant
HAP	LS.02.01.10	Compliant
HAP	LS.02.01.20	Compliant
HAP	LS.02.01.30	Compliant
HAP	LS.02.01.34	Compliant
HAP	LS.02.01.35	Compliant
HAP	MM.01.01.01	Compliant
HAP	MM.01.01.03	Compliant
HAP	MM.03.01.01	Compliant
HAP	MM.03.01.03	Compliant
HAP	MM.04.01.01	Compliant
HAP	MS.01.01.01	Compliant
HAP	MS.03.01.01	Compliant
HAP	MS.08.01.03	Compliant
HAP	NPSG.03.06.01	Compliant
HAP	NPSG.15.01.01	Compliant

HAP	PC.01.02.03	Compliant
HAP	PC.01.02.07	Compliant
HAP	PC.01.03.01	Compliant
HAP	PC.02.01.03	Compliant
HAP	PC.02.01.11	Compliant
HAP	PC.02.02.03	Compliant
HAP	PC.02.03.01	Compliant
HAP	PC.03.05.03	Compliant
HAP	RC.01.01.01	Compliant
HAP	RC.02.01.01	Compliant
HAP	RI.01.01.01	Compliant
HAP	UP.01.03.01	Compliant
HAP	WT.01.01.01	Compliant
HAP	WT.04.01.01	Compliant
CAH	EC.02.02.01	Compliant
CAH	EC.02.03.03	Compliant
CAH	EC.02.03.05	Compliant
CAH	EC.02.04.03	Compliant
CAH	EC.02.05.01	Compliant
CAH	EC.02.05.05	Compliant
CAH	EC.02.05.09	Compliant
CAH	LD.04.03.09	Compliant
CAH	LS.02.01.10	Compliant
CAH	LS.02.01.35	Compliant
CAH	MM.03.01.01	Compliant
CAH	MM.03.01.03	Compliant
CAH	MM.05.01.01	Compliant
CAH	MM.05.01.11	Compliant
CAH	NPSG.03.05.01	Compliant
CAH	NPSG.03.06.01	Compliant
CAH	PC.01.02.01	Compliant
CAH	PC.04.01.05	Compliant
CAH	RC.01.01.01	Compliant
CAH	RI.01.01.03	Compliant

CoP: §485.618 **Tag:** C-0200 **Deficiency:** Compliant

Corresponds to: CAH

Text: §485.618 Condition of Participation: Emergency Services

The CAH provides emergency care necessary to meet the needs of its inpatients and outpatients.

CoP Standard	Tag	Corresponds to	Deficiency
§485.618(b)	C-0202	CAH - MM.03.01.03/EP2	Compliant

CoP: §485.623 **Tag:** C-0220 **Deficiency:** Compliant

Corresponds to: CAH

Text: §485.623 Condition of Participation: Physical Plant and Environment

CoP Standard	Tag	Corresponds to	Deficiency
§485.623(d)(1)	C-0231	CAH - EC.02.03.03/EP3, EC.02.03.05/EP2, LS.02.01.10/EP10, LS.02.01.35/EP4	Compliant
§485.623(b)(2)	C-0223	CAH - EC.02.02.01/EP5	Compliant
§485.623(b)(1)	C-0222	CAH - EC.02.04.03/EP3, EC.02.05.05/EP6, EC.02.05.09/EP5	Compliant

---

CoP: §485.638 **Tag:** C-0300 **Deficiency:** Compliant

Corresponds to: CAH

Text: §485.638 Condition of Participation: Clinical Records

CoP Standard	Tag	Corresponds to	Deficiency
§485.638(a)(4)(iv)	C-0307	CAH - RC.01.01.01/EP11	Compliant

CoP: §482.13 **Tag:** A-0115 **Deficiency:** Compliant

Corresponds to: HAP

Text: §482.13 Condition of Participation: Patient's Rights

A hospital must protect and promote each patient's rights.

CoP Standard	Tag	Corresponds to	Deficiency
§482.13(e)(4)(i)	A-0166	HAP - PC.03.05.03/EP2	Compliant
§482.13(c)(2)	A-0144	HAP - NPSG.15.01.01/EP2	Compliant

CoP: §482.23 **Tag:** A-0385 **Deficiency:** Compliant

Corresponds to: HAP

Text: §482.23 Condition of Participation: Nursing Services

The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse.

CoP Standard	Tag	Corresponds to	Deficiency
§482.23(c)(6)(ii)(D)	A-0413	HAP - MM.03.01.01/EP2	Compliant
§482.23(c)(3)	A-0406	HAP - MM.04.01.01/EP13	Compliant
§482.23(b)(4)	A-0396	HAP - PC.01.03.01/EP1	Compliant

CoP: §482.24 **Tag:** A-0431 **Deficiency:** Compliant

Corresponds to: HAP

Text: §482.24 Condition of Participation: Medical Record Services

The hospital must have a medical record service that has administrative responsibility for medical records. A medical record must be maintained for every individual evaluated or treated in the hospital.

CoP Standard	Tag	Corresponds to	Deficiency
§482.24(c)(1)	A-0450	HAP - RC.01.01.01/EP19	Compliant
§482.24(b)	A-0438	HAP - RC.01.01.01/EP8	Compliant

CoP: §482.25 **Tag:** A-0489 **Deficiency:** Compliant

Corresponds to: HAP

Text: §482.25 Condition of Participation: Pharmaceutical Services

The hospital must have pharmaceutical services that meet the needs of the patients. The institution must have a pharmacy directed by a registered pharmacist or a drug storage area under competent supervision. The medical staff is responsible for developing policies and procedures that minimize drug errors. This function may be delegated to the hospital's organized pharmaceutical service.

CoP Standard	Tag	Corresponds to	Deficiency
§482.25(b)(2)(iii)	A-0504	HAP - MM.03.01.01/EP6	Compliant
§482.25(b)(2)(i)	A-0502	HAP - MM.03.01.01/EP3	Compliant
§482.25(b)(3)	A-0505	HAP - MM.03.01.01/EP8	Compliant
§482.25(b)	A-0500	HAP - MM.03.01.01/EP5	Compliant

CoP: §482.41 **Tag:** A-0700 **Deficiency:** Compliant

Corresponds to: HAP - EC.02.06.01/EP1

Text: §482.41 Condition of Participation: Physical Environment

The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community.

CoP Standard	Tag	Corresponds to	Deficiency
§482.41(a)	A-0701	HAP - EC.02.02.01/EP5, EC.02.05.01/EP8, EC.02.06.01/EP1, EP26	Compliant
§482.41(b)(1)(ii)	A-0710	HAP - LS.02.01.30/EP3, EP11	Compliant
§482.41(c)		HAP - EC.02.05.09/EP7	Compliant
§482.41(b)(1)(i)	A-0710	HAP - EC.02.03.03/EP1, LS.02.01.10/EP1, EP5, EP7, EP10, LS.02.01.20/EP11, EP36, LS.02.01.30/EP18, EP19, LS.02.01.34/EP4, LS.02.01.35/EP4, EP5, EP6, EP14, EP10, EP11	Compliant
§482.41(d)(2)	A-0724	HAP - EC.02.03.05/EP3, EP15, EP16, EC.02.04.03/EP3, EC.02.05.05/EP6, EC.02.05.09/EP5	Compliant
§482.41(d)(4)	A-0726	HAP - EC.02.05.01/EP16	Compliant

CoP: §482.42 **Tag:** A-0747 **Deficiency:** Compliant

Corresponds to: HAP - IC.02.01.01/EP1, IC.02.02.01/EP4, EC.02.05.01/EP15, EC.02.06.05/EP2

Text: §482.42 Condition of Participation: Infection Control

The hospital must provide a sanitary environment to avoid sources and transmission of infections and communicable diseases. There must be an active program for the prevention, control, and investigation of infections and communicable diseases.

CoP: §482.51 **Tag:** A-0940 **Deficiency:** Compliant

Corresponds to: HAP - IC.02.02.01/EP2, EP4

Text: §482.51 Condition of Participation: Surgical Services

If the hospital provides surgical services, the services must be well organized and provided in accordance with acceptable standards of practice. If outpatient surgical services are offered the services must be consistent in quality with inpatient care in accordance with the complexity of services offered.

CoP: §485.635 **Tag:** C-0270 **Deficiency:** Compliant

Corresponds to: CAH

Text: §485.635 Condition of Participation: Provision of Services

CoP Standard	Tag	Corresponds to	Deficiency
§485.635(c)(4)(ii)	C-0292	CAH - LD.04.03.09/EP6	Compliant
§485.635(a)(3)(iv)	C-0276	CAH - MM.03.01.01/EP3, MM.05.01.11/EP2	Compliant

CoP: §482.12 **Tag:** A-0043 **Deficiency:** Compliant

Corresponds to: HAP - LD.01.03.01/EP12

Text: §482.12 Condition of Participation: Governing Body

There must be an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body.

CoP: §482.22 **Tag:** A-0338 **Deficiency:** Compliant

Corresponds to: HAP

Text: §482.22 Condition of Participation: Medical staff

The hospital must have an organized medical staff that operates under bylaws approved by the governing body, and which is responsible for the quality of medical care provided to patients by the hospital.

CoP Standard	Tag	Corresponds to	Deficiency
§482.22(c)	A-0353	HAP - MS.01.01.01/EP1, EP5	Compliant
§482.22(c)(5)(i)	A-0358	HAP - PC.01.02.03/EP4, MS.01.01.01/EP16	Compliant

SUPPLEMENTAL #1
September 22, 2017
10:08 am

STATE OF TENNESSEE, BLEDSOE COUNTY:

This is to certify that I, Sandra S. Dodson, published the attached notice in *The Bledsonian-Banner*, a newspaper published in Bledsoe County, Tennessee, for 1 ~~consecutive~~ weeks, beginning the 7TH day of SEPTEMBER, 2017, as required by law.

This 8TH day of SEPTEMBER, 2017.

Sandra S Dodson
Publisher

Sworn and subscribed to before me this 8th day of September, 2017.

Kathy J Mitchell
Notary Public

KATHY J. MITCHELL
STATE OF TENNESSEE NOTARY PUBLIC
BLEDSOE COUNTY

My commission expires: 7/25/20

NOTIFICATION OF INTENT TO APPLY FOR A CERTIFICATE OF NEED

This is to provide official notice to the Health Services & Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 et. seq., and the Rules of the Health Services & Development Agency, that Erlanger Sequatchie Valley Regional Hospital, with an ownership type of governmental, and to be managed by itself, intends to file an application for a Certificate of Need ("CON") to construct a provider based (free standing) emergency department in Pikeville, Bledsoe County, Tennessee.

This facility will replace the existing Erlanger Bledsoe Hospital – Provider Based ED, located at 16931 Rankin Avenue, Dunlap, TN 37327. The new Erlanger Sequatchie Valley Regional Hospital – Provider Based ED will be located at 553 U.S. Highway 127 Bypass, Pikeville, Bledsoe County, Tennessee, 37367, otherwise described as beginning at an iron rod set situated in the northeastern corner of the property at South 18 degrees 34 minutes 40 seconds West, 1,128.65 feet to a monument situated in the right of way of the U.S. Highway 127 Bypass; then South 17 degrees 4 minutes 0 seconds East 792.01 feet to an iron rod set; then North 17 degrees 4 minutes 0 seconds East 560.61 feet to the beginning.

A companion CON application will be filed with the Health Services & Development Agency for the new Erlanger Sequatchie Valley Regional Hospital in Dunlap, Sequatchie County, Tennessee, to replace the existing Erlanger Bledsoe Hospital at 71 Wheelertown Avenue, Pikeville, Bledsoe County, Tennessee.

The total project cost is estimated to be $4,388,481.00.

The anticipated date of filing the application is September 12, 2017.

The contact person for this project is Joseph M. Winick, Sr. Vice President, Erlanger Health System, 975 East 3rd Street, Chattanooga, Tennessee, 37403, and by phone at (423) 778-7274.

Upon written request by interested parties, a local Fact-Finding public hearing shall be conducted. Written requests for hearing should be sent to:

Health Services & Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

Pursuant to T.C.A. § 68-11-1607(c)(1): (A) Any health care institution wishing to oppose a Certificate Of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

children's
Hospital at Erlanger

T.C. Thompson Children's Hospital Campus
910 Blackford Street · Chattanooga, TN 37403
423-778-KIDS (5437)
www.erlanger.org/childrens

September 21, 2017

Ms. Stephanie Boynton
VP & Chief Executive Officer
Erlanger Bledsoe Hospital
71 Wheeler Town Avenue
Pikeville, TN 37367

RE: Erlanger Sequatchie Valley Regional Hospital

Dear Stephanie,

Erlanger Children's Hospital is in full support of your efforts to relocate and replace Erlanger Bledsoe Hospital and its provider based emergency department. As one of six designated Comprehensive Regional Pediatric Centers in the State of Tennessee, Erlanger Children's Hospital is positioned to assist you to insure that at least a primary level of pediatric care is available as per standards, including staffing, equipment, training and services. We will work with you to insure that the highest level of pediatric care is available to those in need. Erlanger Children's Hospital will enter into a transfer agreement with you to insure access and continuity of the highest level of pediatric emergency care available.

Please call on us for assistance as needed.

Sincerely,

Don Mueller

Don Mueller
VP and CEO, Children's Hospital at Erlanger

UT erlanger
Behavioral Health

9/15/2017

To Whom It May Concern:

Erlanger Behavioral Health fully supports the proposal to build a new hospital in Dunlap, replacing Erlanger Bledsoe hospital, and to place a free-standing Emergency Room in Pikeville. The new hospital will reduce health disparities among the rural population by increasing accessibility to emergency management and Erlanger's trauma services. It will provide surgical and outpatient services otherwise not available to the local residents without traveling. Erlanger's behavioral health resources will be available to the Dunlap and Pikeville facilities.

This project will expand resources and accessibility of needed services to the rural community provided in a state-of-the-art facility.

Sincerely,

Jennie Mahaffey, M.D.
Medical Director
Erlanger Behavioral Health
979 East 3rd Street, Suite B-1010
Office: (423)778-2965
Fax: (423)778-2966

SUPPLEMENTAL #1
September 22, 2017
10:08 am

Greg B. Wilson Van Buren County Mayor
P.O. Box 217
Spencer, TN 38585

Phone (931)-946-2314
e-mail- mayorgwilson@outlook.com

September 05, 2017

Erlanger Health System
Stephanie Boynton,

I am writing on behalf of the citizens of Van Buren County, in support of the Regional Hospital to be located in Dunlap, TN. I strongly support this endeavor and the focus on reducing Health disparities in this regional concept. I further support clinics in the outlying counties as well. This regional concept is much needed in this area.

Through this letter be it known Van Buren County will support the efforts of Erlanger Health Systems. We look forward to the opportunity to help eliminate Health disparities in our community and achieving Health equality.

Sincerely,
Greg Wilson
Van Buren County Mayor

SUPPLEMENTAL #1
September 22, 2017
10:08 am

Bledsoe County Courthouse
P.O. Box 149
Pikeville, TN 37367

Bledsoe County, Tennessee
Gregg Ridley, County Mayor

Phone 423-447-6855
Fax 423-447-7265
E-mail: *bledsoemayor@bledsoe.net*

August 29, 2017

Dear Ms. Boynton,

Please accept this communication as an expression of support for Erlanger's Sequatchie Valley Medical Enhancement Project to be located in Sequatchie and Bledsoe Counties. The project will consist of a new twenty-five bed critical access hospital to be constructed in Dunlap, and a newly built emergency department in Pikeville.

The current medical facility, Erlanger Bledsoe is located in Pikeville, and is approaching fifty-years in operation, while utilizing the original structure. The current building is in need of substantial modernization, in order to maintain desired current hospital standards. By locating the new hospital in Dunlap, the newly constructed modern medical facility will centralize health care, in a center location, for the entire Sequatchie Valley.

The central location will offer enhanced accessibility throughout the region. The residents of Pikeville, Bledsoe County, and surrounding areas will have improved access to "State of the Art" emergency services linked to trauma services provided by Erlanger. With this new proximity, the hospital will become more economically viable, allowing for essential services, such as surgery and outpatient care that will limit the need for area residents to leave the Sequatchie Valley, in order to receive their healthcare services.

Erlanger's management of this new centrally located facility will be beneficial to the entire region. Our residents will gain access to a broad range of medical programs and services, such as trauma care and specialty physicians located in Chattanooga.

As Bledsoe County Mayor, I have had the privilege of working with Erlanger for eleven years. Erlanger has demonstrated their commitment to the region and to the citizens they serve. I believe Erlanger's continued operation will launch better health care to more people in the surrounding areas, and provide much needed health care to our rural region.

Sincerely,

Gregg Ridley
Bledsoe County Mayor

22 Cherry Street East
P.O. Box 595
Dunlap, Tennessee 37327

Phone: (423) 949-3479
Fax: (423) 949-2579
seqexec@bledsoe.net

SUPPLEMENTAL #1
September 22, 2017
10:08 am

Sequatchie County Executive

August 29, 2017

To whom it may concern;

Re: Letter of Support to build a new full service 25 bed critical access hospital in Dunlap and a new Emergency Department to be built in Pikeville.

In regards to the above captioned, we are in full support of the capital outlay commitment that will be required to achieve needed quality healthcare here in the Sequatchie Valley. Here are a few of the reasons why;

- The current Erlanger Bledsoe facility is nearly 50 years old and is in need of substantial modernization to meet current hospital standards.
- Placing the new hospital in Dunlap will centralize the hospital in the Sequatchie Valley, making it more accessible to more people throughout the region. Residents of Pikeville, Bledsoe County and the surrounding area will have improved access to "state of the art" emergency services linked to trauma services provided by Erlanger.
- With increased access, the hospital will be economically viable.
- The new hospital will provide essential services that will limit the need for area residents to leave the valley for their healthcare. This will include surgery and outpatient services.
- It will be beneficial for the hospital to be operated by Erlanger to gain access to a broad range of program and services including trauma care and specialty physicians located in Chattanooga. Erlanger has demonstrated its commitment to the region and to those served. Approval will help to bring health care services to more people in the surrounding area
- It is vital that residents in rural areas have access to needed medical care.

If you have any questions, please do not hesitate calling me personally at 423-949-3479 or e- mailing me at seqexec@bledsoe.net.

Thank you.

D. Keith Cartwright
Sequatchie County Executive

SUPPLEMENTAL #1
September 22, 2017
10:08 am

ERLANGER
COMMUNITY HEALTH CENTERS

OUR MISSION STATEMENT:
To Be The Leader In Providing Comprehensive, High Quality, Community-Oriented Healthcare With The Goal of Being The Primary Care Medical Home of Choice In The Communities We Serve By Providing Quality Health Services With Justice, Equality, and Respect.

September 15, 2017

Ms. Stephanie Boynton, CEO
Erlanger Bledsoe Hospital
71 Wheelertown Avenue
Pikeville, TN 37367

Dear Stephanie;

I am pleased to write this letter in support of your hospital initiatives. Placing the hospital in Dunlap will centralize the hospital in the Sequatchie Valley, making it more accessible to more people throughout the region. The new hospital will provide essential services that will limit the need for area residents to leave the valley for their healthcare. We appreciate and support the mission, value and quality of services that it brings to the residents and communities we serve.

Residents of Pikeville, Bledsoe County and the surrounding area will have improved access to "state of the art" emergency services linked to trauma services provided by Erlanger. Approval will help to bring health care services to more people in the surrounding area. It is vital that residents in rural areas have access to needed medical care.

These initiatives will continue to support our mission to provide quality care and expanded access to our region. Our organization appreciates the opportunity to work in partnership and collaboration on an ongoing basis to improve access and the quality of care for the populations we serve.

Sincerely,

Angel Moore, Esq.
Chief Executive Officer
Erlanger Community Health Centers

Supplemental- #2
-COPY-

Chattanooga Hamilton County Hospital Authority dba Erlanger Sequatchie Valley Regional Hospital

CN1709-028

SUPPLEMENTAL INFORMATION *(No. 2)*

Chattanooga-Hamilton County Hospital Authority

D / B / A

Erlanger Sequatchie Valley Regional Hospital

Application To Relocate & Replace The Existing

Provider Based (Free Standing) Emergency Department From

Erlanger Bledsoe Hospital - Satellite ED
(Dunlap, Sequatchie County, TN)

To

Erlanger Sequatchie Valley Regional Hospital - Satellite ED
(Pikeville, Bledsoe County, TN)

Application Number CN1709-028

ERLANGER HEALTH SYSTEM
Chattanooga, Tennessee

SUPPLEMENTAL #2
September 27, 2017
10:22 am

Supplemental Responses To Questions Of The Tennessee Health Services & Development Agency

1.) Section A, Executive Summary.

Your response is noted. Why was the decision not made to keep the hospital in Bledsoe County and the satellite ED in Sequatchie County ?

How will the current ED satellite location in Sequatchie County be utilized, if the proposed project is approved ?

Response

We opted to relocate the hospital and ED so that each would be able to serve the service area population, now and in the future, given roads and population in this rural geography The 2017 population for Bledsoe County is estimated to approximate 13,353 persons with a growth rate expected to approximate 1.4 %thru 2021. For Sequatchie County, the current estimated population is 16,125 with projected growth at 6.7% thru 2021. Add in a portion of Grundy County, with 13,353 persons, reflecting a potential total service area population of approximately 30,000 persons for the hospital site in Sequatchie County. The distance between the sites necessitated that service also be provided in Bledsoe County which is why we opted to put the ED at that location. Routes 111, 127, 28 and 4 make Sequatchie the location most appropriate for the hospital.

The current ED in Sequatchie County is leased from Sequatchie County for $1/year. The site also houses the EMS service for Sequatchie County and an Erlanger primary care practice. These services will remain. The space vacated by the ED will be repurposed as a multispecialty suite in support of the new hospital located approximately ¼ mile down and across the street.

2.) Section A, Floor Plan.

It is noted on pages 116 and 117 of the publication of the Emergency Department Design: A Practical Guide to Planning, the minimum ED volume for determining the size of an emergency department is 10,000 visits per

year (please see the table on the next page of this supplemental). Since the applicant is projecting 44% less annual visits than the 10,000 annual visit minimum required for planning purposes in the ED planning guide, please explain what guidelines were used in determining the proposed ED's total gross square footage, number of beds and estimated area per bed.

Emergency Department Design: A Practical Guide to Planning, 2016, American College of Emergency Physicians-High and Low Estimates for dept. areas and beds							
Minimum Projected Annual Visits (ACEP Planning Guide)	*Dept. Gross Area*		*Bed Quantities*				
	Low Range	*High Range*	*Low Range Bed Qty.*	*Low Range Visits/Bed*	*High Range Bed Qty.*	*High Range Visits/Bed*	*Estimated Area /Bed*
10,000	*8,250*	*12,031*	*8*	*1,250*	*11*	*909*	*875*
Applicant- Satellite ED							
Applicant's Projected Visits Yr. 1	*Total Gross Square Footage*		*Beds*		*Visits Per Bed*		*Estimated Area /Bed*
5,600	*8,100*		*12*		*466*		*675*

Using pages 116 and 117 of the publication of the *Emergency Department Design: A Practical Guide to Planning*, what would be the maximum number of ED visits the proposed ED could handle in a year if this project is approved.

Response

We sized the ED utilizing a programmatic methodology similar to that utilized by the American College of Emergency Physicians as follows.

Average Treatment Time/Patient= 100 minutes or 1.66 hours/patients
(see attached data from CDC)
Projected utilization – 5,678 visits (year 2)
Demand Time/Peak Utilization -6-10 pm daily (4 hours)

Exam Rooms Required

5,678 visits x 1.66 hours/treatment = 9,425 Treatment Hours
9,425/Treatment hours/365 days/4 hours = 6.45 Treatment Rooms
(Needed at Peak Demand)
6.45 Treatment Rooms x 1.2 Adjustment for Unanticipated Demand = 7.7

Rooms Required (7 Provided)

We also utilized the minimum guidelines for design and construction of health care facilities to size each of the rooms, support spaces and circulation to determine the net and gross square footage required. We compared this information to that provided by the American College of Emergency Physicians. While similar in capacity, the proposed space for the ED at 8, 100 sf is below that specified by ACEP.

Using the ACEP methodology, this provider based ED could accommodate a maximum of 10,000 visits per year.

3.) Section B, Need, Item 1 (Project specific Criteria - Freestanding Emergency Department) Determination Of Need.

It is noted the applicant considers the proposed FSED will be designed as a low range facility since it is located in a rural area. However, according to pages 109-112 of the ACEP Emergency Department Design: A Practical Guide to Planning, being located in a rural area is not a factor in determining if your future emergency department will be designed in the low range or in the high range category. Please discuss how the satellite ED is projected to fall with respect to being in the low range, mid-range, or high range acuity by using table 5.2 on pages 109-112 of the ACEP Emergency Department Design: A Practical Guide to Planning.

Response

From the criteria presented in Table 5.2 on pp. 109-112 of the ACEP Planning Guide, the ED in Bledsoe County would be classified as "mid-range". This is because 16.3% of the patients are 65 years of age, older.

4.) Section B, Need, Item F.

The response to the following requested chart is noted. However, it appears the Main ED and Satellite ED calculations in Year One are incorrect. Please clarify and correct the following chart if needed.

Erlanger Sequatchie Valley and Satellite ED Historical and Projected Utilization
Emergency Severity Index Level of Care

Level of Care	Main ED	Main ED	Main ED	Main ED	Satellite ED	Combined Year 1
	2014	2015	2016	Year 1	Year 1	
Level I						
Level II						
Level III						
Level IV						
Level V						
Total						

Response

Please excuse the error as noted, a corrected chart is below.

Erlanger Sequatchie Valley & Satellite ED - Historical & Projected Utilization
Emergency Severity Index - Level Of Care

	========== Main ED ==========			Main ED	Sat. ED	Total
Level Of Care	2014	2015	2016	Year 1	Year 1	Year 1
Level I	17	7	24	11	23	34
Level II	2,215	1,904	2,120	5,665	2,140	7,805
Level III	2,770	2,332	2,351	4,114	2,374	6,488
Level IV	1,024	1,034	967	1,108	975	2,083
Level V	79	64	84	102	88	190
Total	6,105	5,341	5,546	11,000	5,600	16,600

SUPPLEMENTAL #2
September 27, 2017
10:22 am

A F F I D A V I T

STATE OF TENNESSEE |
|
COUNTY OF HAMILTON |

NAME OF FACILITY Erlanger Sequatchie Valley Regional Hospital - Satellite Emergency Department

I, Joseph M. Winick, after first being duly sworn, State under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

SIGNATURE

SWORN to and subscribed before me this 26 of September, 2017, a Notary Public in and for the
Month Year

State of Tennessee, County of Hamilton.

SHELIA HALL
STATE OF TENNESSEE NOTARY PUBLIC
HAMILTON COUNTY

Shelia Hall
NOTARY PUBLIC

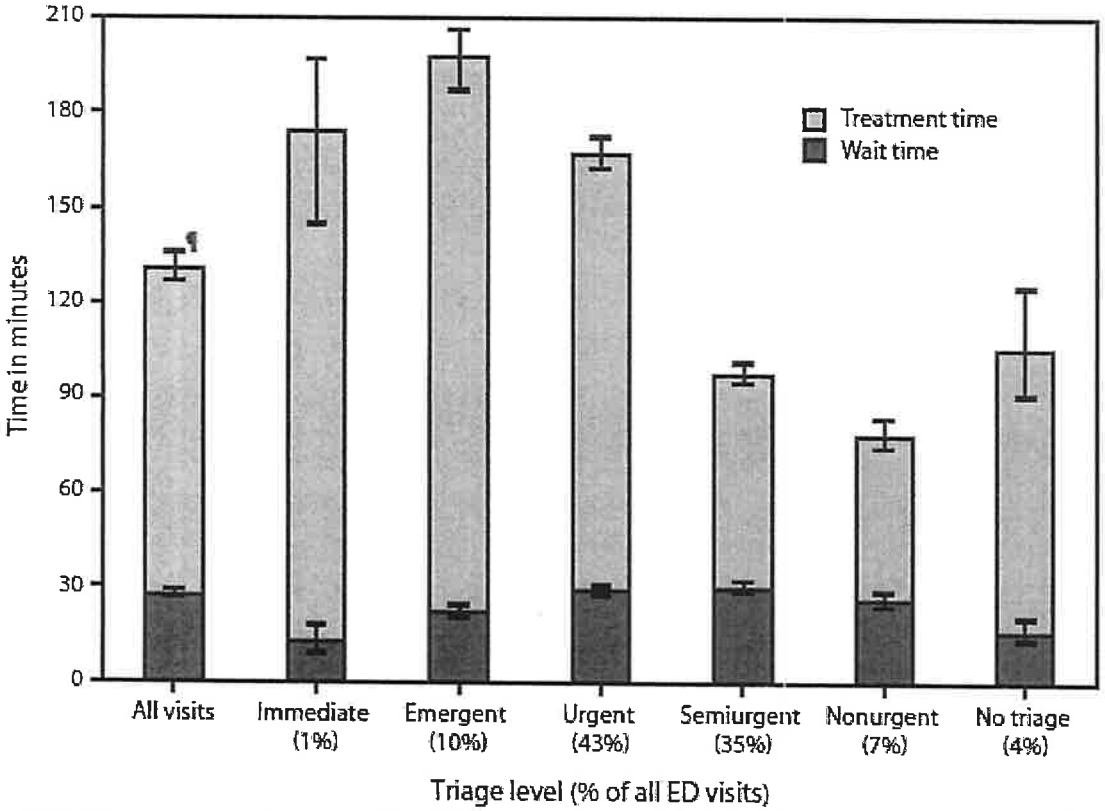
My Commission expires June 9, 2018.
(Month / Day)

ATTACHMENTS

Centers for Disease Control and Prevention
CDC 24/7: Saving Lives. Protecting People.™
Morbidity and Mortality Weekly Report (*MMWR*)

QuickStats: Median Emergency Department (ED) Wait and Treatment Times,* by Triage Level† — National Hospital Ambulatory Medical Care Survey, United States, 2010–2011§

Weekly
May 16, 2014 / 63(19);439



* Wait time was defined as the difference between the time of arrival in the ED and the time the patient had initial contact with a physician, physician assistant, or nurse practitioner. Treatment time was defined as the difference between the time the patient had initial

contact with a physician, physician assistant, or nurse practitioner and the time the patient was discharged from the ED to another hospital unit or to the patient's residence.

† Triage level was based on a five-point scale: 1 = immediate, 2 = emergent, 3 = urgent, 4 = semiurgent, and 5 = nonurgent. No triage was defined as a visit to an emergency service area that did not conduct nursing triage. Triage level was imputed for 19.5% of records included in this analysis. Emergency service areas using three or four level triage systems had their responses rescaled to fit the five level system. In 2010 and 2011, rescaling was required for approximately 12.0% of records.

§ Estimates are based on 2-year annual averages. Approximately 16.9% of records were excluded from this analysis for the following reasons: patient not seen by a physician, physician assistant, or nurse practitioner; record missing wait or length of visit times; treatment time = 0; or disposition of left after triage, left against medical advice, transferred, or dead on arrival.

¶ 95% confidence interval.

The median wait time to be treated in the ED was about 30 minutes, and the median treatment time was slightly more than 90 minutes in 2010–2011. At visits in which patients were triaged, the shortest median wait time was 12 minutes for patients who had an immediate need to be seen. Treatment times were longer for patients who were triaged as immediate, emergent, and urgent compared with those who were triaged as semiurgent or nonurgent.

Source: National Hospital Ambulatory Medical Care Survey 2010-2011. Available at http://www.cdc.gov/nchs/ahcd.htm.

Reported by: Linda F. McCaig, MPH, lmccaig@cdc.gov, 301-458-4365; Michael Albert, MD.

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Alternate Text: The figure above shows median emergency department (ED) wait and treatment times, by triage level in the United States during 2010-2011. The median wait time to be treated in the ED was about 30 minutes, and the median treatment time was slightly more than 90 minutes in 2010-2011. At visits in which patients were triaged, the shortest median wait time was 12 minutes for patients who had an immediate need to be seen. Treatment times were longer for patients who were triaged as immediate, emergent, and urgent compared with those who were triaged as semiurgent or nonurgent.

SEP '17 AM 11:09

LETTER OF INTENT
TENNESSEE HEALTH SERVICES & DEVELOPMENT AGENCY

The Publication of Intent is to be published in The Bledsonian – Banner, a newspaper of general circulation in Bledsoe County, Tennessee, on or before September 7, 2017, for one day.

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This is to provide official notice to the Health Services & Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 *et. seq.*, and the Rules of the Health Services & Development Agency, that Erlanger Sequatchie Valley Regional Hospital, with an ownership type of governmental, and to be managed by itself, intends to file an application for a Certificate of Need ("CON") to construct a provider based (free standing) emergency department in Pikeville, Bledsoe County, Tennessee.

This facility will replace the existing Erlanger Bledsoe Hospital – Provider Based ED, located at 16931 Rankin Avenue, Dunlap, TN 37327. The new Erlanger Sequatchie Valley Regional Hospital – Provider Based ED will be located at 553 U.S. Highway 127 Bypass, Pikeville, Bledsoe County, Tennessee, 37367, otherwise described as beginning at an iron rod set situated in the northeastern corner of the property at South 18 degrees 34 minutes 40 seconds West, 1,128.65 feet to a monument situated in the right of way of the U.S. Highway 127 Bypass; then South 17 degrees 4 minutes 0 seconds East 792.01 feet to an iron rod set; then North 17 degrees 4 minutes 0 seconds East 560.61 feet to the beginning.

A companion CON application will be filed with the Health Services & Development Agency for the new Erlanger Sequatchie Valley Regional Hospital in Dunlap, Sequatchie County, Tennessee, to replace the existing Erlanger Bledsoe Hospital located at 71 Wheelertown Avenue, Pikeville, Bledsoe County, Tennessee.

The total project cost is estimated to be $ 4,388,481.00.

The anticipated date of filing the application is September 12, 2017.

The contact person for this project is Joseph M. Winick, Sr. Vice President, Erlanger Health System, 975 East 3rd Street, Chattanooga, Tennessee, 37403, and by phone at (423) 778-7274.

Joseph M. Winick	September 6, 2017	Joseph.Winick@erlanger.org
	Date:	E-Mail:

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The Letter Of Intent must be filed in triplicate and received between the first and the tenth day of the month. If the last day for filing is a Saturday, Sunday or State Holiday, filing must occur on the preceding business day. File this form at the following address:

Health Services & Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243

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The published Letter Of Intent must contain the following statement pursuant to T.C.A. §68-11-1607(c)(1): (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

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RULES
OF
HEALTH SERVICES AND DEVELOPMENT AGENCY

CHAPTER 0720-11
CERTIFICATE OF NEED PROGRAM – GENERAL CRITERIA

TABLE OF CONTENTS

0720-11-.01 GENERAL CRITERIA FOR CERTIFICATE OF NEED. The Agency will consider the following general criteria in determining whether an application for a certificate of need should be granted:

(1) Need. The health care needed in the area to be served may be evaluated upon the following factors:

(a) The relationship of the proposal to any existing applicable plans;

(b) The population served by the proposal;

(c) The existing or certified services or institutions in the area;

(d) The reasonableness of the service area;

(e) The special needs of the service area population, including the accessibility to consumers, particularly women, racial and ethnic minorities, TennCare participants, and low-income groups;

(f) Comparison of utilization/occupancy trends and services offered by other area providers;

(g) The extent to which Medicare, Medicaid, TennCare, medically indigent, charity care patients and low income patients will be served by the project. In determining whether this criteria is met, the Agency shall consider how the applicant has assessed that providers of services which will operate in conjunction with the project will also meet these needs.

(2) Economic Factors. The probability that the proposal can be economically accomplished and maintained may be evaluated upon the following factors:

(a) Whether adequate funds are available to the applicant to complete the project;

(b) The reasonableness of the proposed project costs;

(c) Anticipated revenue from the proposed project and the impact on existing patient charges;

(d) Participation in state/federal revenue programs;

(e) Alternatives considered; and

(f) The availability of less costly or more effective alternative methods of providing the benefits intended by the proposal.

(Rule 0720-11-.01, continued)

(3) Quality. Whether the proposal will provide health care that meets appropriate quality standards may be evaluated upon the following factors:

(a) Whether the applicant commits to maintaining an actual payor mix that is comparable to the payor mix projected in its CON application, particularly as it relates to Medicare, TennCare/Medicaid, Charity Care, and the Medically Indigent;

(b) Whether the applicant commits to maintaining staffing comparable to the staffing chart presented in its CON application;

(c) Whether the applicant will obtain and maintain all applicable state licenses in good standing;

(d) Whether the applicant will obtain and maintain TennCare and Medicare certification(s), if participation in such programs was indicated in the application;

(e) Whether an existing healthcare institution applying for a CON has maintained substantial compliance with applicable federal and state regulation for the three years prior to the CON application. In the event of non-compliance, the nature of non-compliance and corrective action shall be considered;

(f) Whether an existing health care institution applying for a CON has been decertified within the prior three years. This provision shall not apply if a new, unrelated owner applies for a CON related to a previously decertified facility;

(g) Whether the applicant will participate, within 2 years of implementation of the project, in self-assessment and external peer assessment processes used by health care organizations to accurately assess their level of performance in relation to established standards and to implement ways to continuously improve.

1. This may include accreditation by any organization approved by Centers for Medicare and Medicaid Services (CMS) and other nationally recognized programs. The Joint Commission or its successor, for example, would be acceptable if applicable. Other acceptable accrediting organizations may include, but are not limited to, the following:

(i) Those having the same accrediting standards as the licensed hospital of which it will be a department, for a Freestanding Emergency Department;

(ii) Accreditation Association for Ambulatory Health Care, and where applicable, American Association for Accreditation of Ambulatory Surgical Facilities, for Ambulatory Surgical Treatment Center projects;

(iii) Commission on Accreditation of Rehabilitation Facilities (CARF), for Comprehensive Inpatient Rehabilitation Services and Inpatient Psychiatric projects;

(iv) American Society of Therapeutic Radiation and Oncology (ASTRO), the American College of Radiology (ACR), the American College of Radiation Oncology (ACRO), National Cancer Institute (NCI), or a similar accrediting authority, for Megavoltage Radiation Therapy projects;

(v) American College of Radiology, for Positron Emission Tomography, Magnetic Resonance Imaging and Outpatient Diagnostic Center projects;

(Rule 0720-11-.01, continued)

(vi) Community Health Accreditation Program, Inc., Accreditation Commission for Health Care, or another accrediting body with deeming authority for hospice services from CMS or state licensing survey, and/or other third party quality oversight organization, for Hospice projects;

(vii) Behavioral Health Care accreditation by the Joint Commission for Nonresidential Substitution Based Treatment Center, for Opiate Addiction projects;

(viii) American Society of Transplantation or Scientific Registry of Transplant Recipients, for Organ Transplant projects;

(ix) Joint Commission or another appropriate accrediting authority recognized by CMS, or other nationally recognized accrediting organization, for a Cardiac Catheterization project that is not required by law to be licensed by the Department of Health;

(x) Participation in the National Cardiovascular Data Registry, for any Cardiac Catheterization project;

(xi) Participation in the National Burn Repository, for Burn Unit projects;

(xii) Community Health Accreditation Program, Inc., Accreditation Commission for Health Care, and/or other accrediting body with deeming authority for home health services from CMS and participation in the Medicare Quality Initiatives, Outcome and Assessment Information Set, and Home Health Compare, or other nationally recognized accrediting organization, for Home Health projects; and

(xiii) Participation in the National Palliative Care Registry, for Hospice projects.

(h) For Ambulatory Surgical Treatment Center projects, whether the applicant has estimated the number of physicians by specialty expected to utilize the facility, developed criteria to be used by the facility in extending surgical and anesthesia privileges to medical personnel, and documented the availability of appropriate and qualified staff that will provide ancillary support services, whether on- or off-site.

(i) For Cardiac Catheterization projects:

1. Whether the applicant has documented a plan to monitor the quality of its cardiac catheterization program, including but not limited to, program outcomes and efficiencies;

2. Whether the applicant has agreed to cooperate with quality enhancement efforts sponsored or endorsed by the State of Tennessee, which may be developed per Policy Recommendation; and

3. Whether the applicant will staff and maintain at least one cardiologist who has performed 75 cases annually averaged over the previous 5 years (for an adult program), and 50 cases annually averaged over the previous 5 years (for a pediatric program).

(j) For Open Heart projects:

1. Whether the applicant will staff with the number of cardiac surgeons who will perform the volume of cases consistent with the State Health Plan (annual average of the previous 2 years), and whether the applicant will maintain this volume in the future;

2. Whether the applicant will staff and maintain at least one surgeon with 5 years of experience;

3. Whether the applicant will participate in a data reporting, quality improvement, outcome monitoring, and peer review system that benchmarks outcomes based on national norms, with such a system providing for peer review among professionals practicing in facilities and programs other than the applicant hospital (demonstrated active participation in the STS National Database is expected and shall be considered evidence of meeting this standard);

(k) For Comprehensive Inpatient Rehabilitation Services projects, whether the applicant will have a board-certified physiatrist on staff (preferred);

(l) For Home Health projects, whether the applicant has documented its existing or proposed plan for quality data reporting, quality improvement, and an outcome and process monitoring system;

(m) For Hospice projects, whether the applicant has documented its existing or proposed plan for quality data reporting, quality improvement, and an outcome and process monitoring system;

(n) For Megavoltage Radiation Therapy projects, whether the applicant has demonstrated that it will meet the staffing and quality assurance requirements of the American Society of Therapeutic Radiation and Oncology (ASTRO), the American College of Radiology (ACR), the American College of Radiation Oncology (ACRO), National Cancer Institute (NCI), or a similar accrediting authority;

(o) For Neonatal Intensive Care Unit projects, whether the applicant has documented its existing or proposed plan for data reporting, quality improvement, and outcome and process monitoring system; whether the applicant has documented the intention and ability to comply with the staffing guidelines and qualifications set forth by the Tennessee Perinatal Care System Guidelines for Regionalization, Hospital Care Levels, Staffing and Facilities; and whether the applicant will participate in the Tennessee Initiative for Perinatal Quality Care (TIPQC);

(p) For Nursing Home projects, whether the applicant has documented its existing or proposed plan for data reporting, quality improvement, and outcome and process monitoring systems, including in particular details on its Quality Assurance and Performance Improvement program. As an alternative to the provision of third party accreditation information, applicants may provide information on any other state, federal, or national quality improvement initiatives;

(q) For Inpatient Psychiatric projects:

1. Whether the applicant has demonstrated appropriate accommodations for patients (e.g., for seclusion/restraint of patients who present management problems and children who need quiet space; proper sleeping and bathing arrangements for all patients), adequate staffing (i.e., that each unit will be staffed with at least two direct patient care staff, one of which shall be a nurse, at all

times), and how the proposed staffing plan will lead to quality care of the patient population served by the project;

2. Whether the applicant has documented its existing or proposed plan for data reporting, quality improvement, and outcome and process monitoring system; and

3. Whether an applicant that owns or administers other psychiatric facilities has provided information on satisfactory surveys and quality improvement programs at those facilities.

(r) For Freestanding Emergency Department projects, whether the applicant has demonstrated that it will satisfy and maintain compliance with standards in the State Health Plan;

(s) For Organ Transplant projects, whether the applicant has demonstrated that it will satisfy and maintain compliance with standards in the State Health Plan; and

(t) For Relocation and/or Replacement of Health Care Institution projects:

1. For hospital projects, Acute Care Bed Need Services measures are applicable; and

2. For all other healthcare institutions, applicable facility and/or service specific measures are applicable.

(u) For every CON issued on or after the effective date of this rule, reporting shall be made to the Health Services and Development Agency each year on the anniversary date of implementation of the CON, on forms prescribed by the Agency. Such reporting shall include an assessment of each applicable volume and quality standard and shall include results of any surveys or disciplinary actions by state licensing agencies, payors, CMS, and any self-assessment and external peer assessment processes in which the applicant participates or participated within the year, which are relevant to the health care institution or service authorized by the certificate of need. The existence and results of any remedial action, including any plan of correction, shall also be provided.

(v) HSDA will notify the applicant and any applicable licensing agency if any volume or quality measure has not been met.

(w) Within one month of notification the applicant must submit a corrective action plan and must report on the progress of the plan within one year of that submission.

(4) Contribution to the Orderly Development of Adequate and Effective Healthcare Facilities and/or Services. The contribution which the proposed project will make to the orderly development of an adequate and effective health care system may be evaluated upon the following factors:

(a) The relationship of the proposal to the existing health care system (for example: transfer agreements, contractual agreements for health services, the applicant's proposed TennCare participation, affiliation of the project with health professional schools);

(b) The positive or negative effects attributed to duplication or competition; and

(Rule 0720-11-.01, continued)

(c) The availability and accessibility of human resources required by the proposal, including consumers and related providers.

(5) Applications for Change of Site. When considering a certificate of need application which is limited to a request for a change of site for a proposed new health care institution, The Agency may consider, in addition to the foregoing factors, the following factors:

(a) Need. The applicant should show the proposed new site will serve the health care needs in the area to be served at least as well as the original site. The applicant should show that there is some significant legal, financial, or practical need to change to the proposed new site.

(b) Economic factors. The applicant should show that the proposed new site would be at least as economically beneficial to the population to be served as the original site.

(c) Quality of Health Care to be provided. The applicant should show the quality of health care to be provided will be served at least as well as the original site.

(d) Contribution to the orderly development of health care facilities and/or services. The applicant should address any potential delays that would be caused by the proposed change of site, and show that any such delays are outweighed by the benefit that will be gained from the change of site by the population to be served.

(6) Certificate of need conditions. In accordance with T.C.A. § 68-11-1609, The Agency, in its discretion, may place such conditions upon a certificate of need it deems appropriate and enforceable to meet the applicable criteria as defined in statute and in these rules.

Authority: *T.C.A. §§ 4-5-202, 4-5-208, 68-11-1605, 68-11-1609, and 2016 Tenn. Pub. Acts Ch. 1043.* ***Administrative History:*** *Original rule filed August 31, 2005; effective November 14, 2005. Emergency rule filed May 31, 2017; effective through November 27, 2017.*

CERTIFICATE OF NEED
REVIEWED BY THE DEPARTMENT OF HEALTH
DIVISION OF POLICY, PLANNING AND ASSESSMENT
615-741-1954

DATE: November 30, 2017

APPLICANT: Erlanger Sequatchie Valley Regional Hospital FSED
533 U.S. Highway 127 Bypass
Pikeville, Tennessee 37367

CONTACT PERSON: Joseph M. Winnick
Erlanger Health System
975 East 3rd Street
Chattanooga, Tennessee 37403

COST: $4,388,484

In accordance with Section 68-11-1608(a) of the Tennessee Health Services and Planning Act of 2002, the Tennessee Department of Health, Division of Policy, Planning, and Assessment, reviewed this certificate of need application for financial impact, TennCare participation, compliance with *Tennessee's State Health Plan*, and verified certain data. Additional clarification or comment relative to the application is provided, as applicable, under the heading "Note to Agency Members."

SUMMARY:
Erlanger Sequatchie Valley Regional Hospital Satellite ED seeks Certificate of Need (CON) approval to relocate and replace an existing provider based emergency department, from Dunlap, Sequatchie County, to Pikeville, Bledsoe County. This facility will replace the Erlanger Bledsoe Hospital-provider based ED.

A companion CON application will be filed for the new Erlanger Valley Regional Hospital in Dunlap, Sequatchie County, to replace the existing Erlanger Bledsoe Hospital located at 71 Wheelertown Avenue, Pikeville, Bledsoe County, Tennessee.

The total project cost is $4,388,481 and will be financed by Bledsoe County, Tennessee.

GENERAL CRITERIA FOR CERTIFICATE OF NEED

The applicant responded to all of the general criteria for Certificate of Need as set forth in the document *Tennessee's State Health Plan.*

NEED:
The service area is Bledsoe County. The 2017 population of Bledsoe County is 13,333, increasing to 13,516 in 2021, an increase of 1.4%.

This proposed facility will replace the existing Erlanger Bledsoe Hospital-Provider Based ED that has been located in Dunlap Tennessee since 2013.

The need for a provider based emergency department in Pikeville is further illustrated by the announcement ion July 25, 2017, that Textile Corporation of America will be opening a manufacturing plant and creating 1,000 new jobs. In case of an accidental injury, the provider based emergency department will be readily accessible to this facility.

The applicant reports CMS has already approved this project and has recognized Erlanger Sequatchie Valley Regional Hospital as a necessary critical access hospital (CAH). The letter from CMS recognizes that the replacement hospital to be constructed in Sequatchie County, and the

provider based ED to be constructed in Bledsoe County, as replacements for existing facilities are configured as a single provider as proposed herein.

Erlanger Bledsoe Hospital-Satellite ED opened in 2013 in 2013 in Dunlap, Sequatchie County, Tennessee. With the relocation to Erlanger Sequatchie Valley Regional Hospital, it is necessary to relocate the provider based emergency department to Pikeville, Bledsoe County, Tennessee.

The replacement facility, Erlanger Sequatchie Valley Regional Hospital-Satellite ED will be located in Pikeville, Bledsoe County, Tennessee, about 21 miles north of Erlanger Sequatchie Valley Regional Hospital, as described in the companion CON application. The provider based emergency department in Dunlap will be closed concurrently with the opening of Erlanger Sequatchie Valley Regional Hospital.

The reasoning behind relocating the provider based ED from Sequatchie County to Bledsoe County is to foster access by placing an ED within a reasonable distance of the population of Bledsoe County and the surrounding area. The primary service area for Erlanger Sequatchie Valley Regional Hospital Satellite ED is Bledsoe County. Patients will not need to travel to the replacement hospital in Dunlap for needed emergency services.

The original Erlanger Bledsoe Hospital Satellite ED had 5,100 square feet of space and 3 treatment rooms, plus two other rooms. The proposed new Erlanger Sequatchie Valley Hospital Satellite ED will have 8,100 square feet of space, 2 treatment rooms, 2 multi-purpose rooms, 1 orthopedic room, 1 trauma room, 1 triage room, 1 decontamination room, and 4 other treatment rooms.

The applicant projects 5,600 visits in year one or 675 visits per room.

TENNCARE/MEDICARE ACCESS:
The applicant participates in the Medicare and Medicaid programs. The applicant contracts with TennCare MCOs AmeriGroup, United Healthcare Community Plan, BlueCare, and TennCare Select.

The applicant's year one Medicare revenue are projected to be $5,097,928 or 26.7% of total gross revenues, and TennCare revenues are projected to be $6,644,491, or 34.8% of total gross revenues.

ECONOMIC FACTORS/FINANCIAL FEASIBILITY:
The Department of Health, Division of Policy, Planning, and Assessment have reviewed the Project Costs Chart, the Historical Data Chart, and the Projected Data Chart to determine if they are mathematically accurate and if the projections are based on the applicant's anticipated level of utilization. The location of these charts may be found in the following specific locations in the Certificate of Need Application or the Supplemental material:

Project Costs Chart: The Project Cost Chart is located on page 60R2 of the application. The total project cost is $4,388,484.

Historical Data Chart: The Historical Data Chart for the total facility is located on page 63 of the application. The applicant reported 296, 409, and 344 admissions in 2014, 2015 and 2016 with net operating revenues of $602,822, $489,925, and $1,330,420 each year, respectively.

Historical Data Chart: The Historical Data Chart for the Project Only is located on page 65 R. The applicant reported 3,842, 9,581, and 10,229 visits with net operating revenues of $9,616, ($55,325) and (4,933) each year, respectively.

Projected Data Chart: The Projected Data Chart is located on page 68 of the application. The applicant projects 842 admissions in year one and 859 admissions in year two with net operating revenues of $1,297,015 and $1,374,957 each year, respectively.

Proposed Charge Schedule

	Previous Year	Current Year	Year One	Year Two	% Change
Gross Charge	1,245	2,153	3,410	3,613	190.2
Average Deduction	856	1,562	2,568	2,752	221.5
Average Net Charge	389	591	841	860	121.1

Staffing

Title	FTE
Nurse Practitioner	3.0
Pharmacist	2.2
Radiation Tech	5.0
RN	9.2
Med Tech	5.0
Nurse Manager	2.4
	26.8

Project Payor Mix Year One

Payor Source	Projected Gross Operating Revenue	% of Total
Medicare/Medicare Managed Care	5,097,928	26.7
TennCare/Medicaid	6,677,491	34.8
Commercial/Other Managed Care	4,677,874	24.5
Self-Pay	1,699,309	8.9
Charity Care	935,575	4.9
Other	38,188	0.2
Total	19,093,365	100

CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTHCARE:
The applicant will be part of an existing healthcare system and enhance Erlanger Health System's ability to integrate its services within the regional service area as a safety net provider, trauma center, and region's only academic medical center. A list of the patient transfer agreements, along with a list of currently contracted payor organizations is attached to the application.

The effects of this proposal will be positive for the healthcare system because it will help deliver the most appropriate level of care for those who are in need of emergency medical service regardless of ability to pay, and thereby will serve to foster improved access to care.

There are no negative effects of this proposal.

Erlanger Health System, as the region's only academic medical center, has established strong long term relationships with the region's colleges, universities, and clinical programs. Erlanger provides clinical sites for internships and rotation programs in nursing, radiology, respiratory, pharmacy, and surgery technology, to name a few.

Further, affiliation with the University of Tennessee, College of Medicine includes training of senior medical students on clinical rotation as well as graduate medical education for training of residents and advanced fellowships in various specialties.

Erlanger is licensed by the Tennessee Department of Health, Board for Licensing Healthcare Facilities and accredited by The Joint Commission.

QUALITY MEASURES:

SPECIFIC CRITERIA FOR CERTIFICATE OF NEED

The applicant responded to all relevant specific criteria for Certificate of Need as set forth in the document *Tennessee's State Health Plan.*

CERTIFICATE OF NEED STANDARDS AND CRITERIA

FOR

Freestanding Emergency Departments

The Health Services Development Agency (HSDA) may consider the following standards and criteria for applicants seeking to establish or expand Freestanding Emergency Departments (FSEDs). Rationale statements are provided for standards to explain the Division of Health Planning's underlying reasoning. Additionally, these rationale statements may assist stakeholders in responding to these Standards and may assist the HSDA in its assessment of applications. Existing FSEDs are not affected by these standards and criteria unless they take action that requires a new certificate of need (CON) for such services. These proposed standards and criteria will become effective immediately upon approval and adoption by the governor.

The Certificate of Need Standards and Criteria serve to uphold the Five Principles for Achieving Better Health set forth by the State Health Plan. These Principles were first developed for the 2010 edition and have been utilized as the overarching framework of the Plan in each annual update that has followed. Utilizing the Five Principles for Achieving Better Health during the development of the CON Standards and Criteria ensures the protection and promotion of the health of the people of Tennessee. The State Health Plan's Five Principles for Achieving Better Health are as follows:

1. **Healthy Lives:** The purpose of the State Health Plan is to improve the health of people in Tennessee.
2. **Access:** People in Tennessee should have access to health care and the conditions to achieve optimal health.

3. **Economic Efficiencies:** Health resources in Tennessee, including health care, should be developed to address the health of people in Tennessee while encouraging value and economic efficiencies.
4. **Quality of Care:** People in Tennessee should have confidence that the quality of care is continually monitored and standards are adhered to by providers.
5. **Workforce:** The state should support the development, recruitment, and retention of a sufficient and quality health workforce.

Definitions

Rural Area: A proposed service area shall be designated as rural in accordance with the U.S. Department of Health and Human Services (HRSA) Federal Office of Rural Health Policy's *List of Rural Counties and Designated Eligible Census Tracts in Metropolitan Counties*. This document, along with the two methods used to determine eligibility, can be found at the following link:
http://www.hrsa.gov/ruralhealth/resources/forhpeligibleareas.pdf

For more information on the Federal Office of Rural Health Policy visit:
http://www.hrsa.gov/ruralhealth/

Freestanding Emergency Department: A facility that receives individuals for emergency care and is structurally separate and distinct from a hospital. A freestanding emergency department (FSED) is owned and operated by a licensed hospital. These facilities provide emergency care 24 hours a day, 7 days a week, and 365 days a year.

Service Area: Refers to the county or contiguous counties or Zip Code or contiguous Zip Codes represented by an applicant as the reasonable area in which the applicant intends to provide freestanding emergency department services and/or in which the majority of its service recipients reside.

Standards and Criteria

1. **Determination of Need:** The determination of need shall be based upon the existing access to emergency services in the proposed service area. The applicant should utilize the metrics below, as well as other relevant metrics, to demonstrate that the population in the proposed service area has inadequate access to emergency services due to geographic isolation, capacity challenges, or low-quality of care.

The applicant shall provide information on the number of existing emergency department (ED) facilities in the service area, as well as the distance of the proposed FSED from these existing facilities. If the proposed service area is comprised of contiguous ZIP Codes, the applicant shall provide this information on all ED facilities located in the county or counties in which the service area ZIP Codes are located.

The applicant should utilize Centers for Medicare and Medicaid Services (CMS) throughput measures, available from the CMS Hospital Compare website, to illustrate the wait times at existing emergency facilities in the proposed service area. Data provided on the CMS Hospital Compare website does have a three to six month lag. In order to account for the delay in this information, the applicant may supplement CMS data with other more timely data.

ED-1	Median time from ED arrival to ED departure for ED admitted patients
ED-2	Median time from admit decision to departure for ED admitted patients
OP-18	Median time from ED arrival to ED departure for discharged ED patients
OP-20	Door to diagnostic evaluation by a qualified medical professional
OP-22	ED-patient left without being seen

The applicant should also provide data on the number of visits per treatment room per year for each of the existing emergency department facilities in the service area. Applicants should utilize applicable data in the Hospital Joint Annual Report to demonstrate the total annual ED volume and annual emergency room visits of the existing facilities within the proposed service area. All existing EDs in the service area should be operating at capacity. This determination should be based upon the annual visits per treatment room at the host hospital's emergency department (ED) as identified by the American College of Emergency Physicians (ACEP) in *Emergency Department Design: A Practical Guide to Planning for the Future, Second Edition* as capacity for EDs. The capacity levels set forth by this document should be utilized as a *guideline* for describing the potential of a respective functional program. The annual visits per treatment room should exceed what is outlined in the ACEP document.

Because the capacity levels set forth in the Emergency *Department Design: A Practical Guide to Planning for the Future, Second Edition* are labeled in the document as a "preliminary sizing chart", the applicant is encouraged to provide additional evidence of the capacity, efficiencies, and demographics of patients served within the existing ED facility in order to better demonstrate the need for expansion.

Source: https://www.medicare.gov/hospitalcompare/search.html

https://data.medicare.gov/data/hospital-compare

Note: The above measures are found in the category "Timely and Effective Care".

If the applicant is demonstrating low-quality care provided by existing EDs in the service area, the applicant shall utilize the Joint Commission's "Hospital Outpatient Core Measure Set". These measures align with CMS reporting requirements and are available through the CMS Hospital Compare website. Full details of these measures can be found in the Joint Commission's *Specification Manual for National Hospital Outpatient Department Quality Measures*. Existing emergency facilities should be in the bottom quartile of the state in the measures listed below in order to demonstrate low-quality of care.

Sources: https://www.jointcommission.org/hospital_outpatient_department/

https://www.jointcommission.org/assets/1/6/HAP_Outpatient_Dept__Core_Measure_Set.pdf

https://www.medicare.gov/hospitalcompare/search.html

https://data.medicare.gov/data/hospital-compare

Note: The above measures are found in the category "Timely and Effective Care".

The HSDA should consider additional data provided by the applicant to support the need for the proposed FSED including, but not limited to, data relevant to patient acuity levels, age of patients, percentage of behavioral health patients, and existence of specialty modules. These data may provide the HSDA with additional information on the level of need for emergency services in the proposed service area. If providing additional data, applicants should utilize

Hospital Discharge Data System data (HDDS) when applicable. The applicant may utilize other data sources to demonstrate the percentage of behavioral health patients but should explain why the alternative data source provides a more accurate indication of the percentage of behavioral health patients than the HDDS data.

See Standard 2, Expansion of Existing Emergency Department Facility, for more information on the establishment of a FSED for the purposes of decompressing volumes and reducing wait times at the host hospital's existing ED.

Note: Health Planning recognizes that limitations may exist for specific metrics listed above. When significant limitations exist (e.g. there are not adequate volumes to evaluate) applicants may omit these metrics from the application. However, the application should then discuss the limitations and reasoning for omission. Applicants are encouraged to supplement the listed metrics with additional metrics that may provide HSDA with a more complete representation of the need for emergency care services in the proposed service area.

There will be no change in the availability of emergency services in Bledsoe County with approval of this CON application. Erlanger Bledsoe Hospital is the only existing provider of emergency medical care in the service area.

The physical plant deficiencies at Erlanger Bledsoe Hospital require the facility be replaced. For 2016, the average number of emergency visits per room was 1,136 vs. the American College of Emergency Physicians low acuity standard of 1,250 visits per room and the high acuity standard of 909 visits per room. At the same time, the provider based emergency department in Sequatchie County has outgrown its facilities when utilization and capacity are considered with 2,097 visits per room in 2016.

A companion CON application describes Erlanger Sequatchie Regional Hospital to be located in Dunlap, Sequatchie Valley, Tennessee. CMS has indicated that its approval presumes the replacement and relocation of the hospital and provider based emergency department will be the same as currently provided. In Bledsoe County, the emergency department will move approximately 1.2 miles.

2. **Expansion of Existing Emergency Department Facility:** Applicants seeking expansion of the existing host hospital ED through the establishment of a FSED in order to decompress patient volumes should demonstrate the existing ED of

the host hospital is operating at capacity. This determination should be based upon the annual visits per treatment room at the host hospital's emergency department (ED) as identified by the American College of Emergency Physicians (ACEP) in *Emergency Department Design: A Practical Guide to Planning for the Future, Second Edition* as capacity for EDs. The capacity levels set forth by this document should be utilized as a *guideline* for describing the potential of a respective functional program. The applicant shall utilize the applicable data in the Hospital Joint Annual Report to demonstrate total annual ED volume and annual emergency room visits. The annual visits per treatment room should exceed what is outlined in the ACEP document. Because the capacity levels set forth in the Emergency *Department Design: A Practical Guide to Planning for the Future, Second Edition* are labeled in the document as a "preliminary sizing chart", the applicant is encouraged to provide additional evidence of the capacity, efficiencies, and demographics of patients served within the existing ED facility in order to better demonstrate the need for expansion. See Standard 1, Demonstration of Need, for examples of additional evidence.

Additionally, the applicant should discuss why expansion of the existing ED is not a viable option. This discussion should include any barriers to expansion including, but not limited to, economic efficiencies, disruption of services, workforce duplication, restrictive covenants, and issues related to access. The applicant should also provide evidence that all practical efforts to improve efficiencies within the existing ED have been made, including, but not limited to, the review of and modifications to staffing levels.

Applicants seeking to decompress volumes of the existing host hospital ED should be able to demonstrate need for the additional facility in the proposed service area as defined in the application in accordance with Standard 1, Determination of Need.

Not Applicable.

3. **Relationship to Existing Similar Services in the Area:** The proposal shall discuss what similar services are available in the service area and the trends in occupancy and utilization of those services. This discussion shall include the likely impact of the proposed FSED on existing EDs in the service area and shall include how the applicant's services may differ from existing services. Approval of the proposed FSED should be contingent upon the applicant's demonstration

that existing services in the applicant's proposed geographical service area are not adequate and/or there are special circumstances that require additional services.

There are no other providers of emergency department services in Bledsoe County, Tennessee, which is classified as medically underserved. Erlanger Bledsoe Hospital has also received designations as a "necessary provider" from both the State of Tennessee and CMS. As part of a critical access hospital, the emergency department of at Erlanger Bledsoe Hospital and its provider based emergency department in Sequatchie County, meet all access and geographical standards as promulgated for critical access hospitals by CMS.

4. **Host Hospital Emergency Department Quality of Care:** Additionally, the applicant shall provide data to demonstrate the quality of care being provided at the ED of the host hospital. The quality metrics of the host hospital should be in the top quartile of the state in order to be approved for the establishment of a FSED. The applicant shall utilize the Joint Commission's hospital outpatient core measure set. These measures align with CMS reporting requirements and are available through the CMS Hospital Compare website. Full details of these measures can be found in the Joint Commission's *Specification Manual for National Hospital Outpatient Department Quality Measures*.
Sources: https://www.jointcommission.org/hospital_outpatient_department/

https://www.jointcommission.org/assets/1/6/HAP_Outpatient_Dept__Core_Measure_Set.pdf

https://www.medicare.gov/hospitalcompare/search.html

https://data.medicare.gov/data/hospital-compare

Note: The above measures are found in the category "Timely and Effective Care".

Response

Pertaining to the operating metrics identified within this criterion, data is not available for all indicators on the *Medicare Hospital Compare* website. However, data is available for a few of the

indicators, as listed here:

Indicator	*Description*	*Value*
OP-4	Aspirin At Arrival	99 %
OP-18	Median Time From ED Arrival To Departure For Discharged ED Patients	95 min.
OP-20	Door To Diagnostic Eval	25 min.
OP-21	Median Time To Pain Med	49 min.
OP-22	Left Before Being Seen	2 %

A copy of the Medicare Hospital Compare data is attached to this CON application.

Erlanger Bledsoe Hospital compares favorably with both state and national averages. Metrics for the provider based emergency department in Sequatchie County are combined with those of *Erlanger Bledsoe Hospital* as provider based emergency as specified by CMS. *Erlanger Bledsoe Hospital* and its provider based ED are both accredited by *The Joint Commission. Erlanger Sequatchie Valley Regional Hospital* and its provider based emergency department will also be accredited by *The Joint Commission.*

5. **Appropriate Model for Delivery of Care:** The applicant should discuss why a FSED is the appropriate model for delivery of care in the proposed service area.

Response

Erlanger Bledsoe Hospital has demonstrated that its provider based emergency department in Sequatchie County was the right model for the needs of the community as evidenced by the improvements in health status that have been realized since the emergency department was opened. With the Sequatchie County EMS service and a helipad on- site, community residents have timely access to a full range of emergency medical services inclusive of Level I trauma services for adults and children, *Erlanger Medical Center - University Hospital.* As the only Level I trauma service provider, *Erlanger Medical Center - University Hospital* also provides medical supervisory oversight for the entire thirteen (13) county region.to ensure access to timely medical care thru its regional operations center.

As a safety net provider with six (6) helicopters, *Erlanger Health System* provides essential services to that in need. *Erlanger Health System* is the 7th largest public health system in the United States. For the proposed project, it is anticipated that the community benefit in Bledsoe County will be at least equal to that realized with the hospital, though likely greater given the improved facilities and accessible location. As integral providers of *Erlanger Health System,* the

new hospital and its provider based emergency department will have access to highly specialized resources in emergency medicine, Level I trauma services for adult and children, a fleet of air ambulances and a graduate medical training program for Emergency physicians. *Erlanger's* reputation in emergency medicine is national in scope, with *Erlanger Medical Center University Hospital* hosting national trauma meetings and associated educational and credentialing meetings.

Erlanger is one of only a few hospitals in the country that have the ability to raise the standard of care in the delivery of emergency medicine.

6. **Geographic Location:** The FSED should be located within a 35 mile radius of the hospital that is the main provider.

Response

The provider based emergency department in Pikeville, Bledsoe County, will be located approximately twenty two(22) miles from *Erlanger Sequatchie Valley Regional Hospital. B*oth of these sites meet CMS location standards and requirements for a critical access hospital.

7. **Access:** The applicant must demonstrate an ability and willingness to serve equally all of the service area in which it seeks certification. In addition to the factors set forth in HSDA Rule 0720-11-.01(1) (listing factors concerning need on which an application may be evaluated), the HSDA may choose to give special consideration to an applicant that is able to show that there is limited access to ED services in the proposed Service Area.

Response

Erlanger Health System is a safety net provider for Tennessee and has a demonstrated track record of serving all patients regardless of ability to pay. *Erlanger Health System* annually provides more uncompensated care than all other hospitals in the region combined, the annual cost of this care typically exceeds $100 million. *Erlanger Medical Center - University Hospital* is where community hospitals send their most difficult cases. *Erlanger Health System* also operates a "system of care" that facilitates access to a broad range of tertiary services including Level I trauma services for adults and children.

8. **Services to High-Need Populations:** Special consideration shall be given to applicants providing services fulfilling the unique needs and requirements of certain high-need populations, including patients who are uninsured, low income, or patients with limited access to emergency care.

Response

Erlanger Health System is a safety net provider for Tennessee and has a demonstrated track record of serving all patients regardless of ability to pay. *Erlanger Health System* annually provides more uncompensated care than all other hospitals in the region combined, the annual cost of this' care typically exceeds $100 million. *Erlanger Medical Center - University Hospital* is where community hospitals send their most difficult cases.*Erlanger Health System* also operates a "system of care" that facilitates access to a broad range of tertiary services including Level I trauma services for adults and children.

9. **Establishment of Non-Rural Service Area:** The geographic service area shall be reasonable and based on an optimal balance between population density and service proximity of the applicant. The socio-demographics of the service area and the projected population to receive services shall be considered. The applicant shall demonstrate the orderly development of emergency services by providing information regarding current patient origin by ZIP Code for the hospital's existing ED in relation to the proposed service area for the FSED.

   Establishment of a Rural Service Area: Applicants seeking to establish a freestanding emergency department in a rural area with limited access to emergency medical care shall establish a service area based upon need. The applicant shall demonstrate the orderly development of emergency services by providing information regarding patient origin by ZIP Code for the proposed service area for the FSED.

Response

Erlanger Bledsoe Hospital is the only provider of emergency department services in Bledsoe County, Tennessee. *Erlanger Bledsoe Hospital*, through its emergency department locations, currently provides 65.6% of all such services for Bledsoe County; and Erlanger Health System combined provides 76.5% of all emergency department services for Bledsoe County. See table of ED patient destination below.

ED Patient Destination from Bledsoe
County Tennessee
(Bledsoe County =Zip Code 37367

	CY 2014	2015	2016
Erlanger Bledsoe	4,109	4,212	4,322
Erlanger Med Ctr-	648	700	712
Erlanger Sequatchie	174	373	359
Erlanger North Hosp	28	24	31
Erlanger East	22	14	18
Total - Erlanger	**4,981**	**5,323**	**5,442**
Market Share	**70.2%**	**76.1%**	**76.5%**
CHI Memorial Hosp-Hixson	*120*	*102*	*88*
CHI Memorial Hosp-Chat	78	75	65
Parkridge Med Ctr	64	49	22
Parkridge West Hosp	32	20	11
Parkridge East Hosp	22	15	21
Cumberland Med	873	559	631
Rhea Med Ctr	567	558	517
Cookeville Reg Med	108	94	95
Saint Thomas	102	75	76
Saint Thomas River	25	19	22
Other	128	109	124
Total - Bledsoe	**7,100**	**6,998**	**7,114**

10. **Relationship to Existing Applicable Plans; Underserved Area and Population:** The proposal's relationship to underserved geographic areas and underserved population groups shall be a significant consideration.

Response

Erlanger Bledsoe Hospital is the only provider of emergency department services in Bledsoe County, Tennessee. *Erlanger Sequatchie Valley Regional Hospital* will have a helipad that provides access, via *Erlanger* helicopter, to Level I trauma services for adults and children. *Erlanger Medical Center - University Hospital* also provides emergency service oversight for the entire regional service area and is affiliated with the University of Tennessee - College of Medicine, to train emergency physicians, including a fellowship in advanced emergency medicine. *Erlanger Health System* continuously demonstrates its commitment to the underserved. Its effort has

had a direct impact in improving health status for rural underserved communities using independently collected metrics.

11. **Composition of Services:** Laboratory and radiology services, including but not limited to XRAY and CT scanners, shall be available on-site during all hours of operation. The FSED should also have ready access to pharmacy services and respiratory services during all hours of operation.

Response

As with existing ED services provided by *Erlanger Bledsoe Hospital* at both locations, the same services will be provided by *Erlanger Sequatchie Valley Regional Hospital* and its provider based ED in Pikeville, Bledsoe County. Services will be inclusive of on-site X-Ray, CT, Laboratory and Respiratory Therapy. Also, emergency medical professionals will staff the ED twenty-four (24) hours per day.

12. **Pediatric Care:** Applicants should demonstrate a commitment to maintaining at least a Primary Level of pediatric care at the FSED as defined by CHAPTER 1200-08-30 Standards for Pediatric Emergency Care Facilities including staffing levels, pediatric equipment, staff training, and pediatric services. Applicants should include information detailing the expertise, capabilities, and/or training of staff to stabilize or serve pediatric patients. Additionally, applicants shall demonstrate a referral relationship, including a plan for the rapid transport, to at least a general level pediatric emergency care facility to allow for a specialized higher level of care for pediatric patients when required.

Response

Children's Hospital at Erlanger, located in Chattanooga, Tennessee, is a state designated regional pediatric center. Access via *LifeForce* helicopter can be accomplished in a matter of minutes from Pikeville, Bledsoe County. The EMS service for Bledsoe County will be located withinmile of the new emergency department. Staff from *Children's Hospital at Erlanger* provides education and training on appropriate protocol and

treatment of pediatric emergencies. Erlanger Sequatchie Valley Regional Hospital and its provider based ED will each have a helipad to foster patient transfer as needed.

13. **Assurance of Resources:** The applicant shall document that it will provide the resources necessary to properly support the applicable level of emergency services. Included in such documentation shall be a letter of support from the applicant's governing board of directors or Chief Financial Officer documenting the full commitment of the applicant to develop and maintain the facility resources, equipment, and staffing to provide the appropriate emergency services. The applicant shall also document the financial costs of maintaining these resources and its ability to sustain them to ensure quality treatment of patients in the ED continuum of care.

Response

A letter from the CFO for *Erlanger Health System* is attached to this CON application. The letter assures *Erlanger's* commitment to the provider based ED which will be part of *Erlanger Sequatchie Valley Regional Hospital.* This commitment will be to provide necessary resources, operate and staff the provider based ED sufficiently as to ensure high quality care, both within and along the ED continuum. Currently, *Erlanger Bledsoe Hospital* staffs the provider based emergency department in Dunlap, Sequatchie County, with physicians; it is expected that this project will be similarly staffed.

14. **Adequate Staffing:** An applicant shall document a plan demonstrating the intent and ability to recruit, hire, train, assess competencies of, supervise, and retain the appropriate numbers of qualified personnel to provide the services described in the application and that such personnel are available in the proposed service area. Each applicant shall outline planned staffing patterns including the number and type of physicians and nurses. Each FSED is required to be staffed by at least one physician and at least one registered nurse at all times (24/7/365). Physicians staffing the FSED should be board certified or board eligible emergency physicians. If significant barriers exist that limit the applicant's ability to recruit a board certified or board eligible emergency

physician, the applicant shall document these barriers for the HSDA to take into consideration. Applicants are encouraged to staff the FSED with registered nurses certified in emergency nursing care and/or advanced cardiac life support. The medical staff of the FSED shall be part of the hospital's single organized medical staff, governed by the same bylaws. The nursing staff of the FSED shall be part of the hospital's single organized nursing staff. The nursing services provided shall comply with the hospital's standards of care and written policies and procedures.

Adequate Staffing of a Rural FSED: An applicant shall document a plan demonstrating the intent and ability to recruit, hire, train, assess competencies of, supervise, and retain the appropriate numbers of qualified personnel to provide the services described in the application and that such personnel are available in the proposed service area. Each applicant shall outline planned staffing patterns including the number and type of physicians. FSEDs proposed to be located in rural areas are required to be staffed in accordance with the Code of Federal Regulations Title 42, Chapter IV, Subchapter G, Part 485, Subpart F – Conditions of Participation: Critical Access Hospitals (CAHs). This standard requires a physician, nurse practitioner, clinical nurse specialist, or physician assistant be available at all times the CAH operates. The standard additionally requires a registered nurse, clinical nurse specialist, or licensed practical nurse to be on duty whenever the CAH has one or more inpatients. However, because FSEDs shall be in operation 24/7/365 and because they will not have inpatients, a registered nurse, clinical nurse specialist, or licensed practical nurse shall be on duty at all times (24/7/365). Additionally, due to the nature of the emergency services provided at an FSED and the hours of operation, a physician, nurse practitioner, clinical nurse specialist, or physician assistant shall be on site at all times.

Source: http://www.ecfr.gov/cgi-bin/text-idx?rgn=div6&node=42:5.0.1.1.4.4#se42.5.485_1631

Rationale: FSEDs should be staffed with a physician who is board-certified or board-eligible in emergency medicine and a registered nurse in order to ensure the facility is capable of providing the care necessary to treat and/or stabilize patients seeking emergency care. The HSDA should consider evidence provided by the applicant that demonstrates significant barriers to the recruitment a physician who is board-certified or board-eligible in emergency medicine exist.

Rural FSEDs should be awarded flexibility in terms of staffing in accordance with federal regulations. Additionally, flexibility in staffing requirements takes into account the limited availability of medical staff in certain rural regions of the state.

Response
Erlanger Bledsoe Hospital and its provider based ED have continuously operated without interruption and has maintained full accreditation for its services by *The Joint Commission. Erlanger Sequatchie Valley Regional Hospital* does not anticipate difficulties in staffing the provider based ED. There will be essentially no change in ED services.

As a rural CAH, *Erlanger Sequatchie Valley Regional Hospital* will staff the provider based ED in Bledsoe County in compliance with the Code of Federal Regulations, Title 42, Chapter IV, Subchapter G, Part 485, Subpart F - Conditions of Participation: Critical Access Hospitals (CAHs). At all times of operation, a qualified and licensed medical professional will be on-site to render patient care ... such medical professional will be either a physician, nurse practitioner, clinical nurse specialist, or physician assistant. Additionally, a registered nurse, clinical nurse specialist, or licensed practical nurse will also be on duty.

15. **Medical Records:** The medical records of the FSED shall be integrated into a unified retrieval system with the host hospital.

Response

Erlanger Health System is currently implementing a new EMR system which should be completed in November, 2017. This new EMR system is fully integrated and will serve as a unified retrieval system across all hospitals and ambulatory care sites, including *Erlanger Bledsoe Hospital* and it's provider based ED in Sequatchie County. Upon approval of this project, the same EMR system will be installed in *Erlanger Sequatchie Valley Regional Hospital* and its provider based ED in Pikeville, Bledsoe County, a described in the companion CON application.

16. **Stabilization and Transfer Availability for Emergent Cases:** The applicant shall demonstrate the ability of the proposed FSED to perform stabilizing

treatment within the FSED and demonstrate a plan for the rapid transport of patients from the FSED to the most appropriate facility with a higher level of emergency care for further treatment. The applicant is encouraged to include air ambulance transport and an on-site helipad in its plan for rapid transport. The stabilization and transfer of emergent cases must be in accordance with the Emergency Medical Treatment and Labor Act.

Response

Erlanger Health System prides itself on the "system of care" that it has developed across a four state area, which includes *LifeForce* air ambulance & helicopter transfer, co- located EMS partnerships, emergency medical oversight and supervision, and physician training in emergency medicine. The depth and breadth of emergency medical services are unmatched elsewhere, while being fully integrated across the healthcare delivery system and the entire four (4) state regional service area. Transfer agreements are in place for many community hospitals in the regional service area. Please see the list attached to this CON application.

The provider based ED in Pikeville, Bledsoe County, will have a helipad to accommodate *LifeForce* air ambulance and helicopter transfer. EMS services from Bledsoe County are located within mile of the site for *Erlanger Sequatchie Valley Regional Hospital - Satellite Emergency Department.* As necessary, the stabilization and transfer of emergent cases will be in accordance with the *Emergency Medical Treatment & Labor Act.* *Erlanger's established* system of care" serves to offset the longer EMS express times typically found in a rural market (see attached article).

17. **Education and Signage:** Applicants must demonstrate how the organization will educate communities and emergency medical services (EMS) on the capabilities of the proposed FSED and the ability for the rapid transport of patients from the FSED to the most appropriate hospital for further treatment. It should also inform the community that inpatient services are not provided at the facility and patients requiring inpatient care will be transported by EMS to a full service hospital. The name, signage, and other forms of communication of the FSED shall clearly indicate that it provides care for emergency and/or urgent medical conditions without the requirement of a scheduled appointment. The applicant is encouraged to demonstrate a plan for educating the community on

appropriate use of emergency services contrasted with appropriate use of urgent or primary care.

The memorandum is available at the following link: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/downloads/SCletter08-08.pdf

Response

Erlanger Bledsoe Hospital and its provider based ED have worked extensively with communities to educate them on the provision of services. Signage and naming conventions for *Erlanger Sequatchie Valley Regional Hospital* and its provider based ED, will meet all CMS standards and guidelines. In addition, Erlanger Notes" are delivered live monthly via the County Commission to the community to insure community awareness of essential services. *Erlanger* attributes its success in delivering services to the community, in part, to its efforts to engage and educate the community. The health of the population has shown measurable improvement

18. **Community Linkage Plan:** The applicant shall describe its participation, if any, in a community linkage plan, including its relationships with appropriate health and outpatient behavioral health care system, including mental health and substance use, providers/services, providers of psychiatric inpatient services, and working agreements with other related community services assuring continuity of care. The applicant is encouraged to include primary prevention initiatives in the community linkage plan that would address risk factors leading to the increased likelihood of ED usage.

    Rationale: The State Health Plan moved from a primary emphasis of health care to an emphasis on “health protection and promotion”. The development of primary prevention initiatives for the community advances the mission of the State Health Plan.

Response

As indicated, *Erlanger Health System* has worked extensively to ensure there are no gaps in the provision of needed services. It's "system of care" is well known to provide access to a broad based continuum of services, while ensuring continuity via an integrated EMR system. As a safety net, *Erlanger Bledsoe Hospital* and its provider based ED assure access to all patients, regardless of their ability to pay. This assurance will remain in place with *Erlanger Sequatchie Valley Regional Hospital* and its

provider based ED. *Erlanger Bledsoe Hospital* has worked extensively with communities to educate them on the provision of services. In addition, "Erlanger Notes" are delivered live monthly via the County Commission to the community to insure community awareness of essential services. *Erlanger* attributes its success in delivering services to the community, in part, to its efforts to engage and educate the community. The health of the population has shown measurable improvement.

19. **Data Requirements:** Applicants shall agree to provide the Department of Health and/or the HSDA with all reasonably requested information and statistical data related to the operation and provision of services and to report that data in the time and format requested. As a standard practice, existing data reporting streams will be relied upon and adapted over time to collect all needed information.

Response

Erlanger Sequatchie Valley Regional Hospital and its provider based ED, will provide all reasonably requested information and statistical data related to the operation and provision of services. Also, to report such data as requested.

20. **Quality Control and Monitoring:** The applicant shall identify and document its existing or proposed plan for data reporting, quality improvement, and outcome and process monitoring system. The FSED shall be integrated into the host hospital's quality assessment and process improvement processes.

Response

Erlanger Bledsoe Hospital and its provider based ED are accredited by *The Joint Commission.* They also participate in quality reporting and monitoring, as evidenced by the quality information discussed previously and attached to this CON application. The quality reporting and monitoring will continue with *Erlanger Sequatchie Valley Regional Hospital* and its provider based ED.

21. **Provider-Based Status:** The applicant shall comply with regulations set forth by 42 CFR 413.65, *Requirements for a determination that a facility or an organization has provider-based status,* in order to obtain provider-based status. The applicant shall demonstrate eligibility to receive Medicare and Medicaid reimbursement, willingness to serve emergency uninsured patients, and plans to contract with commercial health insurers.

Response

Erlanger Sequatchie Valley Regional Hospital and its provider based ED, as described in the companion CON application, have already received approval from CMS. A copy of the letter is attached to this CON application.

Erlanger Sequatchie Valley Regional Hospital will serve uninsured emergency patients. In addition, all commercial payors which have a contractual agreement with *Erlanger Health System* will be able to access all of these services.

22. **Licensure and Quality Considerations:** Any applicant for this CON service category shall be in compliance with the appropriate rules of the TDH, the EMTALA, along with any other existing applicable federal guidance and regulation. The applicant shall also demonstrate its accreditation status with the Joint Commission or other applicable accrediting agency. The FSED shall be subject to the same accrediting standards as the licensed hospital with which it is associated.

Note: Federal legislation, the Rural Emergency Acute Care Hospital (REACH Act), is under consideration. Under this legislation rural hospitals would be permitted to convert into a FSED and retain CMS recognition. If passage takes place, these standards should be considered revised in order to grant allowance to Tennessee hospitals seeking this conversion in accordance with the federal guidelines.

Response

Erlanger Bledsoe Hospital and it's provider based ED are accredited by *The Joint Commission.*, and they are also in compliance with rules of TDH, EMTALA and other applicable Federal regulations. Such accreditation will be maintained by *Erlanger Sequatchie Valley Regional Hospital* and its provider based ED, upon approval and implementation of this project. A copy of the letter from *The Joint Commission* is attached to this CON application.